**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, visit www.rsa-al.gov. 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?** | $300 individual/$900 family | Generally, you must pay all 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 care 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. $200 per admission.<br>$200 per admission for out-of-network.<br>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?** | $400 individual per calendar year for Major Medical Services; For in-network, there is also an overall calendar year out-of-pocket limit of $9,100 individual / $18,200 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 billing charges, health care this plan does not cover, out-of-network coinsurance, pre-certification penalties, and coinsurance for outpatient mental health and substance abuse 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 |
|---|---|---|---|---|
| | | In-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 | $30 copay / visit<br>No overall deductible | 20% coinsurance | $5 copay for laboratory or pathology per test for in-network may apply; Subject to overall deductible for out-of-network provider |
| | Specialist visit | $35 copay / visit<br>No overall deductible | 20% coinsurance | |
| | Preventive care/screening/ immunization | No charge<br>No overall deductible | Not covered | Visit AlabamaBlue.com/preventiveservices; additional services are available.<br>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<br>No overall deductible | 20% coinsurance | Benefits listed are physician services; facility services are also available; precertification may be required; $5 copay for laboratory or pathology per test for in- network may apply; subject to overall deductible for out-of-network. Precertification is required for advanced imaging (i.e. MRI, MRA, PET, CT and CTA) and genetic testing. For precertification, call 1-800-821-7231. If precertification is not obtained, no benefits are available. |
| | Imaging (CT/PET scans, MRIs) | No charge<br>No overall deductible | 20% coinsurance | |
| **If you need drugs to treat your illness or condition**<br>More information about **prescription drug coverage** is available at express-scripts.com/peehip. | Generic drugs (Tier 1) | $6 copay/prescription days 1-30<br>$12 copay/days 31-60<br>$12 copay/days 61-90 | Same copays as in-network, but you must pay out-of-pocket and submit a paper claim for reimbursement. The plan will reimburse you based on the allowed amount for in-networkpharmacies. | Covers up to a 30-day supply or 90-day supply for approved maintenance medications. Certain drugs may require prior authorization for the plan to pay. Generic equivalent drugs mandatory when available. |
| | Preferred brand drugs (Tier 2) | $40 copay/prescription days 1-30<br>$80 copay/days 31-60<br>$120 copay/days 61-90 | | |
| | Non-preferred brand drugs (Tier 3) | $60 copay/prescription days 1-30<br>$120 copay/days 31-60<br>$180 copay/days 61-90 | | |
| | Specialty drugs (Tier 4) | 20% coinsurance<br>$100 copay (minimum)<br>$150 copay (maximum) | | Covers up to a 30-day supply. Certain drugs may require prior authorization for the plan to pay. Generic equivalent drugs mandatory when available. |

* For more information about limitations and exceptions, see the plan or policy document at https://www.rsa-al.gov/peehip/publications/.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | $150 copay/service<br>No overall deductible | 20% coinsurance | Subject to overall deductible for out-of-network; in Alabama, out-of-network not covered. Procedures requiring precertification include but are not limited to implantable bone conduction hearing aids, knee arthroplasty, lumbar spinal fusion, surgery for obstructive sleep apnea, reduction mammoplasty, rhinoplasty and surgery for varicose veins. For precertification, call 1-800-821-7231. If precertification is not obtained, no benefits are available. |
| | Physician/surgeon fees | No charge<br>No overall deductible | 20% coinsurance | Subject to overall deductible for out-of-network |
| **If you need immediate medical attention** | Emergency room care | $150 copay/facility per visit &<br>$35 copay/physician per visit | $150 copay/facility per visit &<br>$35 copay/physician per visit | Benefits are for medical emergencies and treatment of accidental injuries if treated within 72 hours; Facility and Physician charges for treatment of accidental injuries treated after 72 hours covered at 80% of the allowed amount subject to overall deductible; Facility and Physician services for non-medical emergencies covered at 80% of the allowed amount subject to overall deductible. |
| | Emergency medical transportation | 20% coinsurance | 20% coinsurance | Subject to overall deductible |
| | Urgent care | $30 copay/visit | 20% coinsurance | Subject to overall deductible for out-of-network |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | $200 deductible/admission &<br>$25 copay/day for days 2-5 | $200 deductible/admission &<br>$25 copay/day for days 2-5 & 20% coinsurance | Subject to $200 deductible/admission and $25 copay/day for days 2-5 for in-network facilities and out-of-network facilities outside Alabama; in Alabama, out-of- network benefits are only available for accidental injury; precertification is required for coverage |
| | Physician/surgeon fees | No charge | 20% coinsurance | Subject to overall deductible for out-of-network |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $15 copay/visit for up to 24 visits per year; deductible does not apply and no balance billing when using a Blue Choice Behavioral Network provider. Maximum visits are combined for mental and substance abuse. Additional visits covered if deemed clinically appropriate. | Physician Services: 50% coinsurance, subject to the overall deductible; limited to a maximum of 10 visits per member per plan year for out-of- network. Maximum visits are combined for mental and substance abuse. | For a list of in-network Blue Choice Behavioral Health Network providers, see www.AlabamaBlue.com. Certified Community Mental Health Centers are in-network; $10 copay/visit limited to 20 visits per member per plan year for in-network. Maximum visits are combined for mental and substance abuse. |
| | Inpatient services | Facility Services: No charge/days 1-9 $15 copay/days 10-14 $20 copay/days 15-19 $25 copay/days 20-24 $30 copay/days 25-30<br><br>Physician Services: Mental Health - No charge Substance Abuse – up to 30 days per member per plan year | Facility Services: $200 deductible/admission & $25 copay/day for days 2-5<br><br>Physician Services: 20% coinsurance, subject to the overall deductible | Mental Health – no inpatient day limit per plan year; Substance Abuse – 30-day limit per member per plan year; no lifetime admission maximum. Facility and physician services are only available for short term crisis intervention and until member is stable enough to be moved to PPO hospital; benefits are also available for residential treatment facilities/$20 copay per day. Precertification is required for coverage |
| **If you are pregnant** | Office visits | No charge. No overall deductible | 20% 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 | No charge. No overall deductible | 20% coinsurance | |
| | Childbirth/delivery facility services | $200 deductible/admission & $25 copay/day beginning with the 2nd through the 5th day No overall deductible | 20% coinsurance, subject to $200 deductible/admission & $25 copay/day beginning with the 2nd through the 5th day | |
| **If you need help recovering or have other special health needs** | Home health care | No charge No overall deductible | 20% coinsurance, subject to the overall deductible | Subject to overall deductible for out-of-network outside of Alabama; precertification may be required. Out-of- network not covered within the state of Alabama; benefits are also available for home infusion services. |

* For more information about limitations and exceptions, see the plan or policy document at https://www.rsa-al.gov/peehip/publications/.

| Common Medical Event | Services You May Need | What You Will Pay In-Network Provider (You will pay the least) | What You Will Pay Out-of-Network Provider (You will pay the most) | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | Rehabilitation services | 20% coinsurance; subject to the overall deductible | 20% coinsurance; subject to the overall deductible | Subject to overall deductible; speech therapy is limited to a maximum of 30 visits per member per calendar year. |
| | Habilitation services | 20% coinsurance; subject to the overall deductible | 20% coinsurance; subject to the overall deductible | |
| | Skilled nursing care | Not covered | Not covered | Not covered; member pays 100% |
| | Durable medical equipment | 20% coinsurance, subject to overall deductible | 20% coinsurance, subject to overall deductible | Out-of-network, member responsible for any difference between the charge and the allowed amount |
| | Hospice services | No charge<br>No overall deductible | 20% coinsurance, subject to the overall deductible | 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<br>No overall deductible | Not covered | Visual acuity exam only - rendered by child's pediatrician<br>This is not a comprehensive routine vision plan.<br>Benefits listed are mandated preventive services; visit AlabamaBlue.com/preventiveservices; |
| | Children's glasses | Not covered<br>No overall deductible | Not covered | Not covered; member pays 100% |
| | Children's dental check-up | No charge<br>No overall deductible | Not covered | Dental caries prevention only – rendered by child's pediatrician<br>This is not a comprehensive dental plan.<br>Benefits listed are mandated preventive services; 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
- 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

**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)
- Chiropractic care (Limited to 12 visits per member per calendar year for out-of-network)
- Infertility treatment (Limitations apply)
- 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: state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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: Blue Cross and Blue Shield of Alabama at 1-800-327-3994.

**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 the 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 https://www.rsa-al.gov/peehip/publications/.

## 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 copay/coinsurance | $35/0% |
| Hospital (facility) copay/coinsurance | $25/0% |
| Other copay/coinsurance | $150/20% |

**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 | $230 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$290** |

### 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 copay/coinsurance | $35/0% |
| Hospital (facility) copay/coinsurance | $25/0% |
| Other copay/coinsurance | $150/20% |

**This EXAMPLE event includes services like:**
Primary care physician (*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 | $300 |
| Copayments | $230 |
| Coinsurance | $250 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Joe would pay is** | **$780** |

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

| | |
|---|---|
| The plan's overall deductible | $300 |
| Specialist copay/coinsurance | $35/0% |
| Hospital (facility) copay/coinsurance | $25/0% |
| Other copay/coinsurance | $150/20% |

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

| **Total Example Cost** | **$2,800** |
|---|---|
| **In this example, Mia would pay:** | |
| *Cost Sharing* | |
| Deductibles | $170 |
| Copayments | $610 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $40 |
| **The total Mia would pay is** | **$820** |

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: https://www.rsa-al.gov/peehip/wellness.