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. $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?	$400 individual per calendar year for Major Medical Services; For in-network, there is also an overall calendar year out-of-pocket limit of $8,150 individual / $16,300 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.	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.

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146

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 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 No overall deductible	20% coinsurance	
	Preventive care/screening/ immunization	No charge No overall deductible	Not covered	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 you need 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	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.
	Imaging (CT/PET scans, MRIs)	No charge No overall deductible	20% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://mp.medimpact.com/ala.	Generic drugs (Tier 1)	$6 copay/prescription days 1-30 $12 copay/days 31-60 $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 $80 copay/days 31-60 $120 copay/days 61-90		
	Non-preferred brand drugs (Tier 3)	$60 copay/prescription days 1-30 $120 copay/days 31-60 $180 copay/days 61-90		
	Specialty drugs (Tier 4)	20% coinsurance $100 copay (minimum) $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 http://www.rsa-al.gov/index.php/members/peehip/benefits-policies/.

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 No overall deductible	20% coinsurance	Subject to overall deductible for out-of-network; in Alabama, out-of-network not covered
	Physician/surgeon fees	No charge 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 & $35 copay/physician per visit	$150 copay/facility per visit & $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 & $25 copay/day for days 2-5	$200 deductible/admission & $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 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 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; Precertification is required for coverage
If you are pregnant	Office visits	No charge. No overall deductible	20% coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance 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

* For more information about limitations and exceptions, see the plan or policy document at http://www.rsa-al.gov/index.php/members/peehip/benefits-policies/.

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 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 No overall deductible	Not covered	Visual acuity exam only - rendered by child's pediatrician This is not a comprehensive routine vision plan. Benefits listed are mandated preventive services; visit AlabamaBlue.com/preventiveservices;
	Children's glasses	Not covered No overall deductible	Not covered	Not covered; member pays 100%
	Children's dental check-up	No charge No overall deductible	Not covered	Dental caries prevention only – rendered by child's pediatrician This is not a comprehensive dental plan. Benefits listed are mandated preventive services; visit AlabamaBlue.com/preventiveservices;

* For more information about limitations and exceptions, see the plan or policy document at http://www.rsa-al.gov/index.php/members/peehip/benefits-policies/.

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

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 http://www.rsa-al.gov/index.php/members/peehip/benefits-policies/.

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

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	$40/20%

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	**$12,800**
In this example, Peg would pay:	
Cost Sharing	
Deductibles*	$0
Copayments	$250
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$310**

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	$40/20%

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	**$1,900**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$300
Copayments	$40
Coinsurance	$60
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$400**

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	$40/20%

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	**$7,400**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$20
Copayments	$380
Coinsurance	$0
What isn't covered	
Limits or exclusions	$420
The total Joe 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: www.rsa-al.gov/index.php/members/PEEHIP.

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

Language Access Services and Notice of Nondiscrimination:

The Public Education Employees' Health Insurance Plan (PEEHIP) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. PEEHIP does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

PEEHIP:

- 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, or other formats); and
- 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, at 1-877-517-0020. If you believe that PEEHIP has 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 with: Public Education Employees' Health Insurance Plan, 201 South Union Street, Montgomery, Alabama, 36104, Attn: 1557 Compliance Coordinator, 1-877-517-0020, 1-877-517-0021 (fax), PEEHIP.Info@rsa-al.gov (email). You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Section 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.

Multi-Language Interpreter Services

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-517-0020.

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-517-0020 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1-877-517-0020.

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-517-0020.

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم: Arabic:1-877-517-0020.

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-517-0020.

French: ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-517-0020.

Gujarati: ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હોય, તો ભાષા સહાયતા સેવા, તમારા માટે નિઃશુલ્ક ઉપલબ્ધ છે. 1-855-216-3144 પર કૉલ 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 1-877-517-0020.

Hindi: ध्यान दें: यदद आप ह िंदी बोलते हैं तो आपके लिए मुफ्त में भाषा 1-877-517-0020 पर कॉल करें। सहायता सेवाएं उपलब्ध ह।

Laotian: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-877-517-0020.

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-517-0020.

Portuguese: ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-877-517-0020.

Turkish: DİKKAT: Eğer Türkçe konuşuyor iseniz, dil yardımı hizmetlerinden ücretsiz olarak yararlanabilirsiniz. 1-877-517-0020 irtibat numaralarını arayın.

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。1-877-517-0020 まで、お電話にてご連絡ください。