BlueCross BlueShield of Alabama

Local Government Health Insurance Plan-Group 30000

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 1-800-321-4391 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?	$200 individual; 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. In-network preventive services 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 for in and out-of-network for inpatient facility services. 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?	$8,700 individual/$17,400 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	20% coinsurance	A $20 in-network copay for nurse practitioners, nurse midwives, registered dietician and physician's assistants
	Specialist visit	$50 copay/visit No overall deductible	20% coinsurance	
	Preventive care/screening/ immunization	No Charge No overall deductible	20% coinsurance	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)	No Charge No overall deductible	20% coinsurance	Benefits listed are physician services; facility benefits are also available; lab/pathology $7.50 copay may apply; precertification may be required for coverage
	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 www.optumrx.com	Tier 1 Drugs	$15 copay No overall deductible	Not Covered	Prior authorization required for specific drugs. Tier two and three drugs are covered at 80% after submitting a request for reimbursement through OptumRx, subject to the overall deductible
	Tier 2 Drugs	20% coinsurance	Not Covered	
	Tier 3 Drugs	20% coinsurance	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$100 copay No overall deductible	20% coinsurance	None
	Physician/surgeon fees	No Charge No overall deductible	20% coinsurance	Copay may apply for surgery rendered in an office setting
If you need immediate medical attention	Emergency room care	Accident: No Charge No overall deductible Medical Emergency: $200 copay/visit No overall deductible	Accident: No Charge No overall deductible Medical Emergency: $200 copay/visit No overall deductible	Physician charges will apply

* 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)	
	Emergency medical transportation	20% coinsurance	20% coinsurance	Benefits listed are ground and air ambulance; if ground ambulance provider is out of network, the member is responsible for the 20% coinsurance and any amount billed over the fee schedule
	Urgent care	$40 copay/visit No overall deductible	20% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$200 per admission deductible & $50 copay/day days 2-5 No overall deductible	$200 per admission deductible & $50 copay/day days 2-5 & 20% coinsurance No overall deductible	In Alabama, out-of-network benefits for non-member hospitals are only available for accidental injury and medical emergency; precertification is required
	Physician/surgeon fees	No Charge No overall deductible	20% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$14 copay/visit No overall deductible	20% coinsurance	Benefits listed are for approved LGHIB providers and physician services; Benefits provided by certain in-network providers may be subject to 20% coinsurance; additional benefits are available; precertification is required for intensive outpatient and partial hospitalization; limited to combined maximum of 24 visits for in and out-of-network outpatient mental health and substance abuse per member per calendar year; substance abuse services provided by approved LGHIB providers are limited to 40 visits; benefits are available for Applied Behavioral Analysis (ABA) therapy (precertification required and dollar maximums apply)
	Inpatient services	20% coinsurance $200 per admission for in and out-of-network inpatient facility services. No overall deductible	20% coinsurance $200 per admission for in and out-of-network inpatient facility services. No overall deductible	
If you are pregnant	Office visits	No Charge No overall deductible	20% coinsurance	
	Childbirth/delivery professional services	No Charge No overall deductible	20% coinsurance	

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)	
	Childbirth/delivery facility services	$200 per admission deductible & $50 copay/day days 2-5 No overall deductible	$200 per admission deductible & $50 copay/day days 2-5 & 20% coinsurance No overall deductible	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)
If you need help recovering or have other special health needs	Home health care	20% coinsurance	20% coinsurance	Precertification required; benefits are also available for home infusion services; in Alabama, out-of-network not covered
	Rehabilitation services	20% coinsurance	20% coinsurance	Benefits listed are for Habilitative and Rehabilitation services; precertification required after 15th visit
	Habilitation services	20% coinsurance	20% coinsurance	
	Skilled nursing care	20% coinsurance	20% coinsurance	Precertification is required; benefits only available if approved through case management
	Durable medical equipment	20% coinsurance	20% coinsurance	If provider is out-of-network, the member is responsible for the 20% coinsurance and any amount billed over the fee schedule
	Hospice services	20% coinsurance	20% coinsurance	Precertification required; benefits only available if approved through case management; in Alabama, out-of-network not covered
If your child needs dental or eye care	Children's eye exam	No Charge No overall deductible	20% coinsurance	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	20% coinsurance	Please visit AlabamaBlue.com/preventiveservices

Other Covered Services & Excluded Services:

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; precertification is required) • Chiropractic care (precertification is required after the 18th visit)	• Non-emergency care when traveling outside the U.S. • Infertility Treatment (Assisted Reproductive Technology not covered)

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	• Hearing aids	• Routine foot care
• Cosmetic surgery	• Long-term care (convalescent care)	• Weight loss programs
• Dental care (Adult)	• Routine eye care (Adult)	• Glasses, child

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.

* 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	$200
Specialist copay/coinsurance	$50/0%
Hospital (facility) copay/coinsurance	$50/0%
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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles*	$0
Copayments	$310
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$370

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

The plan's overall deductible	$200
Specialist copay/coinsurance	$50/0%
Hospital (facility) copay/coinsurance	$50/0%
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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$200
Copayments	$580
Coinsurance	$140
What isn't covered	
Limits or exclusions	$40
The total Joe would pay is	$960

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

The plan's overall deductible	$200
Specialist copay/coinsurance	$50/0%
Hospital (facility) copay/coinsurance	$50/0%
Other copay/coinsurance	$40/20%

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*	$200
Copayments	$110
Coinsurance	$270
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$580

Note: These numbers assume the patient does not participate in the plan's managed care program. If you participate in the plan's managed care program, you may be able to reduce your costs. For more information about the managed care program, please contact: AlabamaBlue.com. The Baby Yourself® Maternity program is available to members. For more information, please call 1-800-222-4379. You can also enroll online.
*Note: This plan has other deductibles for specific services included in this coverage example.

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