



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 1-800-239-5772 or visit us at <http://hr.ua.edu/benefits>. 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.bcbosal.org/sbcglossary/ or call 1-800-292-8868 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$400 individual.	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 \$5,000 individual/\$14,300 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-billed charges, health care this plan doesn't cover, cost sharing for most out-of-network benefits, pre-certification penalties, specialty drug coupon program payments 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	20% coinsurance	In Alabama, out-of-network coinsurance is 50%
	Specialist visit	\$55 copay /visit	20% coinsurance	
	Preventive care/screening/immunization	No Charge No overall deductible	Not Covered	Please visit AlabamaBlue.com/preventiveservices . 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)	0% coinsurance	20% coinsurance	Benefits listed are physician services; in Alabama, out-of-network coinsurance is 50% subject to the deductible for Diagnostic Test; in Alabama, out-of-network coinsurance is 50% after a \$35 copay and subject to the deductible for Imaging; facility benefits are also available; precertification may be required.
	Imaging (CT/PET scans, MRIs)	\$35 copay /test	\$35 copay /test & 20% 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	\$15 copay (retail) \$10 copay (mail order)	Not Covered	Prior authorization required for specific drugs; Prescriptions drugs may be dispensed up to a 31-Day supply; Drugs in Specialty Drug Coupon Program, subject to greater of applicable Tier copay or the available payment under the specialty drug coupon program; go to Alabamablue.com/specialtycouponprogramdruglist for a list of these specialty drugs .
	Tier 2 Drugs	\$45 copay (retail) \$35 copay (mail order)	Not Covered	
	Tier 3 Drugs	\$65 copay (retail) \$55 copay (mail order)	Not Covered	
	Tier 4 Drugs	\$125 copay (retail)	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$150 copay	\$150 copay & 20% coinsurance	In Alabama, out-of-network not covered
	Physician/surgeon fees	0% coinsurance	20% coinsurance	In Alabama, out-of-network coinsurance is 50%

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 immediate medical attention	Emergency room care	Accident: \$150 copay /visit Medical Emergency: \$150 copay /visit	Accident: \$150 copay /visit Medical Emergency: \$150 copay /visit	Physician charges will apply
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	\$55 copay /visit	20% coinsurance	In Alabama, out-of-network coinsurance is 50%
If you have a hospital stay	Facility fee (e.g., hospital room)	\$400 per admission copay	\$400 per admission copay & 20% coinsurance	In Alabama, out-of-network benefits are only available for accidental injury and medical emergency; precertification is required
	Physician/surgeon fees	0% coinsurance	20% coinsurance	In Alabama, out-of-network coinsurance is 50%
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$55 copay /visit	20% coinsurance	Benefits listed are physician services; additional benefits are available; may require higher patient responsibility; in Alabama, out-of-network coinsurance is 50%; precertification is required for intensive outpatient, partial hospitalization and inpatient hospitalization
	Inpatient services	0% coinsurance	20% coinsurance	
If you are pregnant	Office visits	0% coinsurance	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); in Alabama, out-of-network coinsurance is 50% for professional services
	Childbirth/delivery professional services	0% coinsurance	20% coinsurance	
	Childbirth/delivery facility services	\$400 per admission copay	\$400 per admission copay & 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)	
If you need help recovering or have other special health needs	Home health care	0% coinsurance	20% coinsurance	In Alabama, out-of-network not covered; benefits are also available for home infusion services; precertification may be required
	Rehabilitation services	20% coinsurance	20% coinsurance	Benefits listed are for Rehabilitative and Habilitative occupational, physical and speech therapy; limited to a maximum of 35 visits per person per therapy each calendar year
	Habilitation services	20% coinsurance	20% coinsurance	Not covered; member pays 100%
	Skilled nursing care	Not Covered	Not Covered	None
	Durable medical equipment	20% coinsurance	20% coinsurance	In Alabama, out-of-network not covered; precertification may be required
	Hospice services	0% coinsurance	20% coinsurance	
If your child needs dental or eye care	Children's eye exam	No Charge No overall deductible	20% coinsurance	Benefits listed are mandated preventive services; please visit AlabamaBlue.com/preventiveservices ; additional benefits are available; limitations apply
	Children's glasses	Not Covered	Not Covered	Not covered; member pays 100%
	Children's dental check-up	No Charge No overall deductible	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"> • Acupuncture • Cosmetic surgery • Dental care (Adult) • Glasses, child 	<ul style="list-style-type: none"> • Hearing aids • Long-term care • Private-duty nursing • Routine foot care 	<ul style="list-style-type: none"> • Skilled nursing 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 for morbid obesity in limited circumstances)
- Infertility treatment (Assisted Reproductive Technology not covered)
- Routine eye care (Adult)
- Chiropractic care (limited to 24 visits per member per calendar year)
- 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: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323 x61565 or www.cciio.cms.gov. If coverage is insured, contact your State insurance regulator regarding your possible rights to continuation coverage under State Law. 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 [1-800-239-5772](tel:1-800-239-5772).

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	\$400	■ The plan's overall deductible	\$400	■ The plan's overall deductible	\$400
■ Specialist copay/coinsurance	\$55/0%	■ Specialist copay/coinsurance	\$55/0%	■ Specialist copay/coinsurance	\$55/0%
■ Hospital (facility) copay/coinsurance	\$400/0%	■ Hospital (facility) copay/coinsurance	\$400/0%	■ Hospital (facility) copay/coinsurance	\$400/0%
■ Other copay/coinsurance	\$150/20%	■ Other copay/coinsurance	\$150/20%	■ Other copay/coinsurance	\$150/20%
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>)		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>)		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>)	
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	\$400	Deductibles	\$400	Deductibles	\$400
Copayments	\$410	Copayments	\$730	Copayments	\$270
Coinsurance	\$0	Coinsurance	\$70	Coinsurance	\$230
<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	\$870	The total Joe would pay is	\$1,240	The total Mia would pay is	\$900

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: <http://hr.ua.edu/benefits>.