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 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. 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 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. The inpatient facility admission deductible is not applied to the overall annual deductible mentioned above.
What is the out–of–pocket limit for this plan?	$10,600 individual/$21,200 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-billed charges, health care this plan doesn't cover, cost sharing for most out-of-network benefits, pre-certification penalties and certain specialty drug manufacturer assistance amounts for some 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	$40 copay/visit Deductible does not apply	20% coinsurance Annual deductible applies	A $20 in-network copay for nurse practitioners, nurse midwives, registered dietician and physician's assistants; precertification is required for some provider administered drugs; if no precertification is obtained, no benefits are available
	Specialist visit	$50 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)	No Charge Deductible does not apply	20% coinsurance Annual deductible applies	Benefits listed are physician services; facility benefits are also available, a facility copay may apply; lab/pathology $7.50 copay may apply; precertification may be required for coverage; if no precertification is obtained, no benefits are available
	Imaging (CT/PET scans, MRIs)	No Charge Deductible does not apply	20% coinsurance Annual deductible applies	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at myprime.com	Tier 1 Drugs	$15 copay Deductible does not apply	Not Covered	Prior authorization required for specific drugs; if no precertification is obtained, no benefits are available. Tier two and three drugs are covered at 80% after submitting a request for reimbursement through Prime Therapeutics, subject to the overall deductible
	Tier 2 Drugs	20% coinsurance	Not Covered	
	Tier 3 Drugs	20% coinsurance	Not Covered	
	Tier 4 Drugs	20% coinsurance	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$100 copay Deductible does not apply	20% coinsurance Annual deductible applies	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 may apply for surgery rendered in an office setting

* 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)	
If you need immediate medical attention	Emergency room care	Accident: No Charge* Deductible does not apply Medical Emergency: $200 copay/visit Deductible does not apply	Accident: No Charge* Deductible does not apply Medical Emergency: $200 copay/visit Deductible does not apply	Physician charges will apply
	Emergency medical transportation	20% coinsurance Annual deductible applies	20% coinsurance Annual deductible applies	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 Deductible does not apply	20% coinsurance Annual deductible applies	Benefits listed are physician copay requirements. In-network provider copays will apply based on the attending provider. Example: Nurse Practitioner urgent care copay will be $20/visit and the Specialist copay will be $50/visit.
If you have a hospital stay	Facility fee (e.g., hospital room)	$200 per admission deductible & $50 copay/day days 2-5	$200 per admission deductible & $50 copay/day days 2-5 & 20% coinsurance	In Alabama, out-of-network benefits for non-member hospitals 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	No charge Deductible does not apply	20% coinsurance Annual deductible applies	Benefits listed are for approved outpatient LGHIB providers; benefits provided by certain other in-network outpatient providers may be subject to applicable medical provider copay; 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 is required; if no precertification is obtained, no benefits are available
	Inpatient services	Physician services: No charge Deductible does not apply Inpatient Facility: $200 per admission deductible & $50 copay/day days 2-5	Physician services: 20% coinsurance Deductible does not apply Inpatient Facility: $200 per admission deductible & $50 copay/day days 2-5 & 20% coinsurance	

* 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)	
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 member enrolls in the Baby Yourself Program within the first two trimesters; precertification is required for some inpatient services; if no precertification is obtained, no benefits are available
	Childbirth/delivery professional services	No Charge Deductible does not apply	20% coinsurance Annual deductible applies	
	Childbirth/delivery facility services	$200 per admission deductible & $50 copay/day days 2-5	$200 per admission deductible & $50 copay/day days 2-5 & 20% coinsurance	
If you need help recovering or have other special health needs	Rehabilitation and Habilitative 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
	Durable medical equipment	20% coinsurance Annual deductible applies	20% coinsurance Annual deductible applies	If 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 and Home Health services	20% coinsurance Annual deductible applies	20% coinsurance Annual deductible applies	Precertification required; if no precertification is obtained, no benefits are available; benefits are also available for home infusion services; benefits only available if approved through case management; in Alabama, out-of-network not covered
	Applied Behavioral Analysis (ABA) Therapy	For children 18 years or younger, covered at 100% of the allowance after $14 copay per visit.	For children 18 years or younger, covered at 80% of the allowance. Annual deductible applies	Precertification is required prior to rendering ABA therapy to determine medical necessity; precertification is also required every six months thereafter to determine medical necessity for continued therapy; if precertification is not obtained, coverage for all services associated with subsequent visits will be denied. For a complete listing of covered services and precertification requirements, please call 1-877-563-9347.

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 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

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

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 1-800-321-4391

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 copayment	$50
Hospital (facility) copayment	$50
Other copayment/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	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$360

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 copayment	$50
Hospital (facility) copayment	$50
Other copayment/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	$600
Coinsurance	$100
What isn't covered	
Limits or exclusions	$40
The total Joe would pay is	$940

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

The plan's overall deductible	$200
Specialist copayment	$50
Hospital (facility) copayment	$50
Other copayment/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	$100
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$600

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.

Language Assistance Services, Auxiliary Aids, Services and Notice of Nondiscrimination only apply to administrative services that Blue Cross and Blue Shield of Alabama provides to your employer.

Discrimination is Against the Law

Language Assistance Services, Auxiliary Aids Services and Notice of Nondiscrimination:

Credence with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (consistent with the scope of sex discrimination described in 45 CFR § 92.101(a)(2)). We do not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Credence Blue Cross and Blue Shield:

- Provides reasonable modifications and free appropriate auxiliary 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 assistance services to people whose primary language is not English, such as qualified interpreters and information written in other languages

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance 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: Credence Blue Cross and Blue Shield, Compliance Office, 450 Riverchase Parkway East, Birmingham, Alabama 35244, Attn: 1557 Compliance Coordinator, 1-833-758-5545, 711 (TTY), 1-205-220-2984 (fax), 1557GrievanceCB@CredenceBlue.com (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.

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

English: ATTENTION: Free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-833-758-5545 (TTY: 711) or call Customer Service.

Arabic: انتباه: إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر أيضًا المساعدات والخدمات الإضافية المناسبة لتوفير المعلومات بتنسيقات يسهل الوصول إليها مجانًا. اتصل بالرقم 1-833-758-5545 (الهاتف النصي: 711) أو الاتصال بخدمة العملاء.

Chinese: 请注意：如果您说 普通话，我们可免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以易读格式向您提供信息。请拨打 1-833-758-5545（TTY 用户请拨 711）或致电客户服务部。

French: À NOTER : Si vous parlez français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et des services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-833-758-5545 (TTY : 711) ou contactez le service client.

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Geeignete Hilfsmittel und Dienstleistungen zur Bereitstellung von Informationen in zugänglichen Formaten sind ebenfalls kostenlos erhältlich. Rufen Sie 1-833-758-5545 (Durchwahl: 711) oder den Kundendienst an.

Gujarati: ધ્યાન આપો: જો તમે ગુજરાતી બોલો છો, તો તમારા માટે નિઃશુલ્ક ભાષા સહાય સેવાઓ ઉપલબ્ધ છે. સુલભ ફોર્મેટમાં માહિતી પ્રદાન કરવા માટેની યોગ્ય સહાય અને સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 1-833-758-5545 (TTY: 711) પર અથવા ગ્રાહક સેવા પર કૉલ કરો.

Hindi: ध्यान दें: अगर आप हिन्दी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएँ उपलब्ध हैं। आसान प्रारूप में सूचना उपलब्ध कराने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 1-833-758-5545 (TTY: 711) पर कॉल करें या ग्राहक सेवा को कॉल करें।

Japanese: ご案内：日本語を話される方には、無料の言語アシスタントサービスをご用意しております。アクセシブルな形式で情報を提供するため、補助器具や支援サービスも無料で提供しております。1-833-758-5545 (TTY: 711) もしくは、カスタマーサービスにお電話でお問合せください。

Korean: 주의: 한국어을(를) 하시면 무료 언어 지원 서비스를 이용하실 수 있습니다. 접근 가능한 형식으로 정보를 제공하기 위한 적절한 보조 도구와 서비스도 무료로 제공됩니다. 1-833-758-5545(TTY: 711)로 전화하거나 고객 서비스에 문의하세요.

Lao: ເອົາໃຈໃສ່: ຖ້າເຈົ້າເວົ້າ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາຟຣີແມ່ນມີໃຫ້ທ່ານ. ການຊ່ວຍເຫຼືອ ແລະ ການບໍລິການທີ່ເໝາະສົມໃນການສະໜອງຂໍ້ມູນໃນຮູບແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້ແມ່ນຍັງສາມາດໃຊ້ໄດ້ໂດຍບໍ່ເສຍຄ່າ.
ໂທ 1-833-758-5545 (TTY: 711) ຫຼື ໂທຫາຜ່າຍບໍລິການລູກຄ້າ.

Portuguese: ATENÇÃO: Se você falar português, serviços gratuitos de assistência linguística estão disponíveis para você. Também estão disponíveis gratuitamente ajudas e serviços auxiliares adequados para fornecer informações em formatos acessíveis. Ligue para 1-833-758-5545 (TTY: 711) ou ligue para o Atendimento ao Cliente.

Russian: ВНИМАНИЕ. Если ваш язык русский язык, к вашим услугам бесплатная языковая помощь. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-833-758-5545 (TTY: 711) или обратитесь в службу поддержки клиентов.

Spanish: ATENCIÓN: Si usted habla español, hay disponibles servicios gratuitos de asistencia lingüística. También hay disponibles, de forma gratuita, ayudas y servicios auxiliares adecuados para dar información en formatos accesibles. Llame al 1-833-758-5545 (TTY: 711) o llame a Servicio al cliente.

Tagalog: ATTENTION: Kung nagsasalita ka ng Tagalog, available sa iyo ang mga libreng serbisyo sa tulong sa wika. Available rin ang naaangkop na mga pantulong na tulong at serbisyo nang walang bayad para magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-833-758-5545 (TTY: 711) o tumawag sa Serbisyo sa Customer.

Turkish: DİKKAT Konuşmanız durumunda Türkçe, ücretsiz dil yardımı hizmetlerinden yararlanabilirsiniz. Erişilebilir formatlarda bilgi sağlamak için uygun yardımcı araçlar ve hizmetler de ücretsiz olarak sunulmaktadır. 1-833-758-5545 (TTY: 711) nolu telefonu veya Müşteri Hizmetlerini arayın.

Vietnamese: CHÚ Ý: Nếu quý vị nói tiếng việt thì dịch vụ hỗ trợ ngôn ngữ miễn phí có sẵn cho quý vị. Chúng tôi cũng có các hỗ trợ và dịch vụ phụ trợ miễn phí phù hợp để cung cấp thông tin ở định dạng dễ tiếp cận. Vui lòng gọi số 1-833-758-5545 (TTY: 711) hoặc gọi Dịch Vụ Khách Hàng.