BlueCross BlueShield of Alabama

SOE 91000

Coverage Period: Beginning on or after 01/01/2012

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Plan Type: PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.bcbsal.com or by calling 1-800-292-8868.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$2500** person **/ $7500** family. Does not apply to preventive, copays, non-covered services, pre-certification penalties and balance-billed charges.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. **$350** person for prescription drug coverage. 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.
Is there an out–of–pocket limit on my expenses?	Yes. **$7500** person.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premium, balance-billed charges, health care this plan doesn't cover, inpatient hospital daily copays, copays to PMD Physicians, coinsurance to non-participating and non-preferred providers, pre-certification penalties, prescription drug deductible and prescription drug copay.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes, this plan uses in-network providers. For a list of in-network providers, see www.bcbsal.com or call 1-800-810-BLUE.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.

Questions: Call 1-800-292-8868 or visit us at www.bcbsal.com.
If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call 1-800-292-8868 to request a copy.

Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use In-Network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use an In Network Provider	Your cost if you use an Out of Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance & $50 copay	50% coinsurance	Subject to overall deductible; not covered outside of Alabama
	Specialist visit	20% coinsurance & $50 copay	50% coinsurance	Subject to overall deductible; not covered outside of Alabama
	Other practitioner office visit	20% coinsurance for chiropractor	Not Covered	Limited to $600 maximum per person for each calendar year; subject to overall deductible
	Preventive care/screening/immunization	No Charge	Not Covered	Please see www.bcbsal.com/preventiveservices
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	50% coinsurance	Subject to overall deductible; facility copay may apply; not covered outside of Alabama
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	Subject to overall deductible; facility copay may apply; precertification may apply; not covered outside of Alabama

Common Medical Event	Services You May Need	Your cost if you use an In Network Provider	Your cost if you use an Out of Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at bcbsal.com/pharmacy.	Generic drugs	0% coinsurance & $20 copay	Not Covered	Subject to prescription drug deductible; prior authorization for specific drugs required for coverage; generic equivalents mandatory when available
	Preferred brand drugs	0% coinsurance & $60 copay	Not Covered	Subject to prescription drug deductible; prior authorization for specific drugs required for coverage; generic equivalents mandatory when available
	Non-preferred brand drugs	0% coinsurance & $80 copay	Not Covered	Subject to prescription drug deductible; prior authorization for specific drugs required for coverage; generic equivalents mandatory when available
	Specialty drugs	0% coinsurance & $80 copay	Not Covered	Subject to prescription drug deductible; prior authorization for specific drugs required for coverage; generic equivalents mandatory when available; subject to preferred brand or non-preferred brand copay
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance & $300 copay	Not Covered	Benefits listed are Tier 1 ; Tier 2 and Tier 3 facilities in Alabama will have higher copay
	Physician/surgeon fees	20% coinsurance	50% coinsurance	Subject to overall deductible; not covered outside of Alabama
If you need immediate medical attention	Emergency room services	0% coinsurance & $300 copay	0% coinsurance & $300 copay	Out of network facility subject to overall deductible; member responsible for 20% coinsurance after deductible and $75 physician copay has been applied

Common Medical Event	Services You May Need	Your cost if you use an In Network Provider	Your cost if you use an Out of Network Provider	Limitations & Exceptions
	Emergency medical transportation	20% coinsurance	20% coinsurance	Subject to overall deductible
	Urgent care	20% coinsurance & $50 copay	50% coinsurance	Subject to overall deductible; not covered outside of Alabama
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance & $300 copay days 1 - 5 per day	Not Covered	Benefits listed are Tier 1. Tier 2 and Tier 3 facilities in Alabama will have higher copay; non-participating hospital not covered except for accidental injury or medical emergency; subject to overall deductible out of network; precertification required for coverage
	Physician/surgeon fee	20% coinsurance	50% coinsurance	Subject to overall deductible; not covered outside of Alabama
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	No Charge	Not Covered	Benefits are available only when using an Expanded Psychiatric Services (EPS) provider
	Mental/Behavioral health inpatient services	No Charge	Not Covered	Benefits are available only when using an Expanded Psychiatric Services (EPS) provider; maximum of 30 days per 12 consecutive months
	Substance use disorder outpatient services	No Charge	Not Covered	Benefits are available only when using an Expanded Psychiatric Services (EPS) provider
	Substance use disorder inpatient services	No Charge	Not Covered	Benefits are available only when using an Expanded Psychiatric Services (EPS) provider; maximum of 30 days per 12 consecutive months
If you are pregnant	Prenatal and postnatal care	20% coinsurance	50% coinsurance	Subject to overall deductible; initial office visit will have a $50 copay for in network services; not covered outside of Alabama

Common Medical Event	Services You May Need	Your cost if you use an In Network Provider	Your cost if you use an Out of Network Provider	Limitations & Exceptions
	Delivery and all inpatient services	20% coinsurance	50% coinsurance	Subject to overall deductible
If you need help recovering or have other special health needs	Home health care	20% coinsurance	Not Covered	Subject to overall deductible
	Rehabilitation services	20% coinsurance	50% coinsurance	Limited to a combined maximum of 15 visits per person each calendar year for physical and occupational therapy; occupational therapy limited to specific procedure and diagnosis codes; speech therapy not covered; subject to overall deductible; not covered outside of Alabama
	Habilitation services	20% coinsurance	50% coinsurance	Limited to a combined maximum of 15 visits per person each calendar year for physical and occupational therapy; occupational therapy limited to specific procedure and diagnosis codes; speech therapy not covered; subject to overall deductible; not covered outside of Alabama
	Skilled nursing care	Not Covered	Not Covered	——————none——————
	Durable medical equipment	20% coinsurance	20% coinsurance	Subject to overall deductible
	Hospice service	20% coinsurance	Not Covered	Subject to overall deductible
If your child needs dental or eye care	Eye exam	No Charge	Not Covered	Limited to 8 services for ages 0-10 per child; 4 services ages 11-21 per child when performed by a pediatrician
	Glasses	Not Covered	Not Covered	——————none——————
	Dental check-up	No Charge	Not Covered	Oral evaluations limited to 3 services for ages 6 months - 6 years per child when performed by a pediatrician

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- **Acupuncture**
- **Bariatric Surgery**
- **Cosmetic surgery**
- **Dental care (Adult)**
- **Glasses, child**
- **Hearing aids**
- **Infertility treatment**
- **Long-term care**
- **Non-emergency care when traveling outside the U.S.**
- **Private-duty nursing**
- **Routine eye care (Adult)**
- **Routine foot care**
- **Skilled nursing care**
- **Weight loss programs**

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- **Chiropractic care**

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-800-292-8868. You may also contact the Alabama Department of Insurance at 334-241-4141 or www.aldoi.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact the Alabama Department of Insurance at 334-241-4141 or www.aldoi.gov

SPANISH (Español): Para obtener asistencia en Español, llame al 1-800-292-8868.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $4,830
- **Patient pays** $2,710

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$1460
Copays	$650
Coinsurance	$450
Limits or exclusions	$150
Total	**$2,710**

Note: These numbers assume the patient has given notice of her pregnancy to the plan. If you are pregnant and have not given notice of your pregnancy, your costs may be higher. For more information, please contact: www.bcbsal.com.

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $2,560
- **Patient pays** $2,840

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$1230
Copays	$1240
Coinsurance	$0
Limits or exclusions	$370
Total	**$2,840**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: www.bcbsal.com.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Call 1-800-292-8868 or visit us at www.bcbsal.com.
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