BlueCross BlueShield of Alabama

Blue Choice Platinum for Business

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 **1-800-292-8868** or visit us at **AlabamaBlue.com/b2021BlueChoicePlatinum**. 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 **AlabamaBlue.com/SBCGlossary** or call **1-800-292-8868** to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$100** individual / **$200** family in-network. **$100** individual / **$200** family out-of-network.	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. In-network preventive services, outpatient hospital services, inpatient hospital services, most physician services, some pediatric dental services, drugs, non-covered services and balance-billed charges 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. **$300** 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?	For in-network **$4,000** individual / **$8,000** 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?	All out-of-network cost sharing amounts (deductibles, copays and coinsurance), except out-of-network mental health disorders & substance abuse medical emergency services, premiums, balance-billed charges and healthcare this plan doesn't cover.	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	$20 copay/visit No overall deductible	20% coinsurance	In Alabama, out-of-network coinsurance is 50%
	Specialist visit	$30 copay/visit No overall deductible	20% coinsurance	
	Preventive care/screening/ immunization	No Charge No overall deductible	Not Covered	Please visit AlabamaBlue.com/PreventiveServices and AlabamaBlue.com/StandardACAPreventiveDrugList. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive, then check your plan benefits for coverage. For a printed copy, please contact Customer Service at **1-800-292-8868**.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge No overall deductible	20% coinsurance	Benefits listed are physician services; in Alabama, out-of-network coinsurance is 50%; in Alabama, out-of-network facilities not covered; some diagnostic tests and imaging may require precertification; if no precertification is obtained, no benefits are available
	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 AlabamaBlue.com/2021SourcePlusRx2DrugList.	Tier 1 Drugs	$10 copay (retail) $25 copay (mail order) No overall deductible	Not Covered	Benefits listed are only available through the ValueONE Network; precertification is required for some drugs; if precertification is not obtained, no coverage
	Tier 2 Drugs	$20 copay (retail) $50 copay (mail order) No overall deductible	Not Covered	
	Tier 3 Drugs	$35 copay (retail) $87.50 copay (mail order) No overall deductible	Not Covered	
	Tier 4 Drugs	$75 copay (retail) $187.50 copay (mail order) No overall deductible	Not Covered	
	Tier 5 Drugs (Preferred Specialty)	$100 copay (retail) No overall deductible	Not Covered	
	Tier 6 Drugs (Non-Preferred Specialty)	$200 copay (retail) No overall deductible	Not Covered	

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$150 copay No overall deductible	20% coinsurance	In Alabama, out-of-network not covered; precertification may be required
	Physician/surgeon fees	No Charge No overall deductible	20% coinsurance	In Alabama, out-of-network coinsurance is 50%
If you need immediate medical attention	Emergency room care	Accident: $150 copay/visit No overall deductible Medical Emergency: $150 copay/visit No overall deductible	Accident: $150 copay/visit Medical Emergency: $150 copay/visit	Physician charges will apply
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	$20 copay/visit No overall deductible	20% coinsurance	In Alabama, out-of-network coinsurance is 50%
If you have a hospital stay	Facility fee (e.g., hospital room)	$150 copay/day for days 1-5 No overall deductible	$300 per admission deductible & 20% coinsurance No overall deductible	In Alabama, out-of-network benefits 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 No overall deductible	20% coinsurance	In Alabama, out-of-network coinsurance is 50%; precertification is required; if no precertification is obtained, no benefits are available
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30 copay/visit No overall deductible	50% coinsurance	Benefits listed are physician services; additional benefits are available; precertification is required for intensive outpatient, partial hospitalization and inpatient hospitalization; outside Alabama, out-of-network outpatient coinsurance is 20% after deductible
	Inpatient services	No Charge No overall deductible	20% coinsurance No overall deductible	
If you are pregnant	Office visits	No Charge No overall deductible	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	No Charge No overall deductible	20% coinsurance	
	Childbirth/delivery facility services	$150 copay/day for days 1-5 No overall deductible	$300 per admission deductible & 20% coinsurance No overall deductible	

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	No Charge No overall deductible	20% coinsurance	In Alabama, out-of-network not covered; precertification is required outside of Alabama; if no precertification is obtained, no benefits are available
	Rehabilitation services	20% coinsurance	20% coinsurance	30 visits per member per calendar year; includes occupational, physical and speech therapy; children ages 0-18 with an autism diagnosis are allowed unlimited visits for occupational and speech therapy; in Alabama, out-of-network coinsurance is 50%
	Habilitation services	20% coinsurance	20% coinsurance	30 visits per member per calendar year; includes occupational, physical and speech therapy; children ages 0-18 with an autism diagnosis are allowed unlimited visits for occupational and speech therapy; in Alabama, out-of-network coinsurance is 50%
	Skilled nursing care	Not Covered	Not Covered	Not covered; member pays 100%
	Durable medical equipment	20% coinsurance	20% coinsurance	In Alabama, out-of-network coinsurance is 50%
	Hospice services	No Charge No overall deductible	20% coinsurance	In Alabama, out-of-network not covered; precertification is required outside of Alabama; if no precertification is obtained, no benefits are available
If your child needs dental or eye care	Children's eye exam	20% coinsurance	Not Covered	Benefits include one eye exam (including refraction) each calendar year for members up to the end of the month in which the member turns 19
	Children's glasses	20% coinsurance	20% coinsurance	Benefits include one pair of prescription glasses (lenses and frames) or contact lenses (limited to one 12-month supply) each calendar year for members up to the end of the month in which the member turns 19
	Children's dental check-up	No Charge No overall deductible	Not Covered	Benefits include diagnostic and preventive services for members up to the end of the month in which the member turns 19; additional benefits available; limitations apply

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.)

- Abortion (except in cases of rape, incest, or when life of the mother is endangered)
- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Long-term care
- Private-duty nursing
- Routine foot care
- 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 morbid obesity in limited circumstances; physician benefits available in-network only and subject to 20% coinsurance)
- Chiropractic care (limited to 15 visits per member per calendar year)
- Infertility treatment (Assisted Reproductive Technology not covered)
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult) (adults age 19 and older, limited to $75 maximum per member for one exam and refraction per calendar year for in-network providers)

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 or your state insurance department.

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/b2021BlueChoicePlatinum.

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** **$100**
- **Specialist copay/coinsurance** **$30/0%**
- **Hospital (facility) copay/coinsurance** **$150/0%**
- **Other copay/coinsurance** **$150/20%**

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** **$100**
- **Specialist copay/coinsurance** **$30/0%**
- **Hospital (facility) copay/coinsurance** **$150/0%**
- **Other copay/coinsurance** **$150/20%**

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*	$100
Copayments	$500
Coinsurance	$10
What isn't covered	
Limits or exclusions	$40
The total Joe would pay is	$650

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

- **The plan's overall deductible** **$100**
- **Specialist copay/coinsurance** **$30/0%**
- **Hospital (facility) copay/coinsurance** **$150/0%**
- **Other copay/coinsurance** **$150/20%**

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*	$100
Copayments	$200
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 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: **AlabamaBlue.com/b2021BlueChoicePlatinum**.
*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

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

Language Access Services and Notice of Nondiscrimination:

Blue Cross and Blue Shield of Alabama, an independent licensee of the Blue Cross and Blue Shield Association, complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. We do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Blue Cross and Blue Shield of Alabama:

- 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, other formats)
- 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. 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: Blue Cross and Blue Shield of Alabama, Compliance Office, 450 Riverchase Parkway East, Birmingham, Alabama 35244, Attn: 1557 Compliance Coordinator, 1-855-216-3144, 711 (TTY), 1-205-220-2984 (fax), 1557Grievance@bcbsal.org (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.

Foreign Language Assistance

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-216-3144 (TTY: 711)

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-216-3144 (TTY: 711)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** 1-855-216-3144 (TTY: 711）。

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-216-3144 (TTY: 711).

Arabic: انتباه: إذا كنت تتحدث العربية، توجد خدمات مساعدة فيما يتعلق باللغة، بدون تكلفة، متاحة لك. اتصل ب1-855-216-3144 (الهاتف النصي: 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-216-3144 (TTY: 711).

French: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-216-3144 (ATS: 711).

French Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-855-216-3144 (TTY: 711).

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 1-855-216-3144 (TTY: 711).

Hindi: ध्यान दें: अगर आपकी भाषा हिंदी है, तो आपके लिए भाषा सहायता सेवाएँ निःशुल्क उपलब्ध हैं। 1-855-216-3144 (TTY: 711) पर कॉल करें।

Laotian: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-855-216-3144 (TTY: 711).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-216-3144 (телетайп: 711).

Portuguese: ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-855-216-3144 (TTY: 711).

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-855-216-3144 (TTY: 711).

Turkish: DİKKAT: Eğer Türkçe konuşuyor iseniz, dil yardımı hizmetlerinden ücretsiz olarak yararlanabilirsiniz. 1-855-216-3144 (TTY: 711) irtibat numaralarını arayın.

Italian: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-216-3144 (TTY: 711).

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。1-855-216-3144（TTY: 711）まで、お電話にてご連絡ください。