**Important Questions** | **Answers** | **Why this Matters:**
--- | --- | ---
What is the overall deductible? | In-network: $750 person / $1,500 family Out-of-network: $1,500 person / $3,000 family Does not apply to in-network preventive services, outpatient hospital services, inpatient hospital services, most physician services and some pediatric dental services; drugs; non-covered services; balance-billed charges; precertification penalties. | 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? | No. | You don’t have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.

Is there an out-of-pocket limit on my expenses? | Yes. In-network: $6,000 person / $12,000 family. | 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? | All out-of-network cost sharing amount (deductibles, copays and coinsurance), except out-of-network mental health disorders & substance abuse medical emergency services; premiums; balance-billed charges; precertification penalties; healthcare this plan doesn’t cover. | 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 AlabamaBlue.com or call 1-800-810-BLUE. The Hospital Choice Network evaluates cost, quality and patient experience in member hospitals. Hospitals are categorized as either Lower Member Cost Share or Higher Member Cost Share, based on their performance. | 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 a referral to see a specialist. | You can see the specialist you choose without permission from this plan.

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.

**Questions:** Call 1-855-350-7437 or visit us at AlabamaBlue.com. If you aren’t clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call 1-855-350-7437 to request a copy.
- **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.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your cost if you use an In Network Provider</th>
<th>Your cost if you use an Out of Network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you visit a health care provider’s office or clinic</strong></td>
<td>Primary care visit to treat an injury or illness</td>
<td>$25 copay/visit</td>
<td>50% coinsurance</td>
<td>Subject to overall deductible for out-of-network; member pays a $40 copay when visiting physicians other than their designated Primary Care Select physician.</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$45 copay/visit</td>
<td>50% coinsurance</td>
<td>Subject to overall deductible for out-of-network; member pays a $60 copay when visiting a specialist not referred by their designated Primary Care Select physician.</td>
</tr>
<tr>
<td></td>
<td>Other practitioner office visit</td>
<td>20% coinsurance for chiropractor</td>
<td>50% coinsurance for chiropractor</td>
<td>Subject to overall deductible; limited to 15 visits per member per calendar year; in Alabama, out-of-network not covered.</td>
</tr>
<tr>
<td></td>
<td>Preventive care/ screening/immunization</td>
<td>No Charge</td>
<td>Not Covered</td>
<td>Please see AlabamaBlue.com/preventiveservices; for a printed copy, please contact Customer Service at 1-800-292-8868.</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>No Charge</td>
<td>50% coinsurance</td>
<td>Benefits listed are for physician services; subject to overall deductible for out-of-network; some diagnostic tests and imaging may require precertification; if no precertification is obtained, no benefits are available.</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>$225 copay/ procedure</td>
<td>50% coinsurance</td>
<td>Benefits listed are for physician services; subject to overall deductible for out-of-network; some diagnostic tests and imaging may require precertification; if no precertification is obtained, no benefits are available.</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>Your cost if you use an In Network Provider</td>
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<tr>
<td>----------------------</td>
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</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td>Tier 1</td>
<td>Retail $10 copay/30-day supply</td>
<td>Not Covered</td>
<td>Benefits are only available through the ValueONE Network; generic drugs mandatory when available; precertification is required for some drugs; if precertification is not obtained, no coverage</td>
</tr>
<tr>
<td></td>
<td>Tier 2</td>
<td>Retail $25 copay/30-day supply</td>
<td>Not Covered</td>
<td>Benefits are only available through the ValueONE Network; generic drugs mandatory when available; precertification is required for some drugs; if precertification is not obtained, no coverage</td>
</tr>
<tr>
<td></td>
<td>Tier 3</td>
<td>Retail $45 copay/30-day supply</td>
<td>Not Covered</td>
<td>Benefits are only available through the ValueONE Network; generic drugs mandatory when available; precertification is required for some drugs; if precertification is not obtained, no coverage</td>
</tr>
<tr>
<td></td>
<td>Tier 4</td>
<td>Retail $90 copay/30-day supply</td>
<td>Not Covered</td>
<td>Benefits listed are only available through the ValueONE Network; member pays 40% with a minimum of either $90 or $225 per prescription; generic drugs mandatory when available; precertification is required for some drugs; if precertification is not obtained, no coverage</td>
</tr>
<tr>
<td></td>
<td>Tier 5 (preferred specialty)</td>
<td>Retail only $175 copay/30-day supply</td>
<td>Not Covered</td>
<td>Benefits are only available through the ValueONE Network; precertification is required for some drugs; if precertification is not obtained, no coverage</td>
</tr>
<tr>
<td></td>
<td>Tier 6 (non-preferred specialty)</td>
<td>Retail only $250 copay/30-day supply</td>
<td>Not Covered</td>
<td>Benefits listed are only available through the ValueONE Network; member pays 20% with a minimum of $250 per prescription; precertification is required for some drugs; if precertification is not obtained, no coverage</td>
</tr>
<tr>
<td><strong>If you have outpatient surgery</strong></td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>Lower Member Cost Share $225 copay/visit</td>
<td>50% coinsurance</td>
<td>Subject to overall deductible for out-of-network; outside Alabama, in-network copay is $1,000; in Alabama, out-of-network not covered; precertification may be required</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>0% coinsurance</td>
<td>50% coinsurance</td>
<td>Subject to overall deductible</td>
</tr>
</tbody>
</table>

More information about **prescription drug coverage** is available at myprime.com/content/dam/prime/memberportal/forms/AuthorForms/IVL/2017/2017_AL_6T_Source+Rx_1.0.pdf
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your cost if you use an In Network Provider</th>
<th>Your cost if you use an Out of Network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room services</td>
<td>$225 copay/visit</td>
<td>$225 copay/visit</td>
<td>Subject to overall deductible for out-of-network; physician charges apply</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>Subject to overall deductible</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$40 copay/visit</td>
<td>50% coinsurance</td>
<td>Subject to overall deductible for out-of-network; member pays a $60 copay when visiting physicians other than their designated Primary Care Select physician</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>Lower Member Cost Share $225 copay/day for days 1-5</td>
<td>Higher Member Cost Share 20% coinsurance/day for days 1-5</td>
<td>Subject to overall deductible for out-of-network; outside Alabama, in-network 30% coinsurance; precertification is required; no benefits are available</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fee</td>
<td>0% coinsurance</td>
<td>50% coinsurance</td>
<td>Subject to overall deductible; precertification is required; if no precertification is obtained, no benefits are available</td>
</tr>
<tr>
<td>If you have mental health, behavioral health, or substance abuse needs</td>
<td>Mental/Behavioral health outpatient services</td>
<td>$45 copay/visit</td>
<td>50% coinsurance</td>
<td>Benefits listed are outpatient physician services and are available through the Blue Choice Behavioral Health Network or PPO physician; member pays a $60 copay when visiting a specialist not referred by their designated Primary Care Select physician; additional benefits are available with higher patient responsibility; precertification is required for intensive outpatient and partial hospitalization; if no precertification is obtained, no benefits are available</td>
</tr>
<tr>
<td></td>
<td>Mental/Behavioral health inpatient services</td>
<td>No Charge</td>
<td>50% coinsurance</td>
<td>Benefits listed are inpatient physician services and are available through the Blue Choice Behavioral Health Network or PPO physician; additional benefits are available with higher patient responsibility; precertification is required; if no precertification is obtained, no benefits are available</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder outpatient services</td>
<td>$45 copay/visit</td>
<td>50% coinsurance</td>
<td>Benefits listed are outpatient physician services and are available through the Blue Choice Behavioral Health Network or PPO physician; additional benefits are available with higher patient responsibility; precertification is required for intensive outpatient and partial hospitalization; if no precertification is obtained, no benefits are available</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder inpatient services</td>
<td>No Charge</td>
<td>50% coinsurance</td>
<td>Benefits listed are inpatient physician services and are available through the Blue Choice Behavioral Health Network or PPO physician; additional benefits are available with higher patient responsibility; precertification is required; if no precertification is obtained, no benefits are available</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Prenatal and postnatal care</td>
<td>0% coinsurance</td>
<td>50% coinsurance</td>
<td>Subject to overall deductible; benefits listed are for outpatient physician services</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>Your cost if you use an In Network Provider</td>
<td>Your cost if you use an Out of Network Provider</td>
<td>Limitations &amp; Exceptions</td>
</tr>
<tr>
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</tr>
<tr>
<td></td>
<td>Delivery and all inpatient services</td>
<td>0% coinsurance</td>
<td>50% coinsurance</td>
<td>Subject to overall deductible; benefits listed are for inpatient physician services</td>
</tr>
<tr>
<td></td>
<td>Home health care</td>
<td>No Charge</td>
<td>50% coinsurance</td>
<td>Precertification is required; in Alabama, out-of-network not covered; subject to overall deductible for out-of-network; if no precertification is obtained outside of Alabama, no benefits are available</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>Subject to overall deductible; limited to a combined maximum of 30 visits for occupational, physical and speech therapy per member per calendar year</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>Subject to overall deductible; limited to a combined maximum of 30 visits for occupational, physical and speech therapy per member per calendar year</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Not covered; member pays 100%</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>Precertification is required; in Alabama, out-of-network not covered; subject to overall deductible for out-of-network; if no precertification is obtained outside of Alabama, no benefits are available</td>
</tr>
<tr>
<td></td>
<td>Hospice service</td>
<td>No Charge</td>
<td>50% coinsurance</td>
<td>Benefits include one eye exam every year for members up to the end of the month in which the member turns 19; subject to overall deductible</td>
</tr>
<tr>
<td></td>
<td>Eye exam</td>
<td>20% coinsurance</td>
<td>Not Covered</td>
<td>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; subject to overall deductible</td>
</tr>
<tr>
<td></td>
<td>Glasses</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td>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; patient responsibility may vary</td>
</tr>
<tr>
<td></td>
<td>Dental check-up</td>
<td>No Charge</td>
<td>Not Covered</td>
<td>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; patient responsibility may vary</td>
</tr>
</tbody>
</table>
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)
- Hearing aids
- Long-term care
- 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 (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.

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 1-855-350-7437. You may also contact your state insurance department at 1-334-269-3550 or Insdept@insurance.alabama.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: Alabama Department of Insurance at 1-334-269-3550 or Insdept@insurance.alabama.gov.

Does this Coverage Provide Minimum Essential Coverage?
The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” This plan or policy does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?
The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

——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.

<table>
<thead>
<tr>
<th>Having a baby (normal delivery)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Amount owed to providers:</strong> $7,540</td>
</tr>
<tr>
<td><strong>Plan pays</strong> $6,140</td>
</tr>
<tr>
<td><strong>Patient pays</strong> $1,400</td>
</tr>
</tbody>
</table>

**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 $800
- Copays $400
- Coinsurance $0
- Limits or exclusions $200

**Total** $1,400

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: AlabamaBlue.com.

<table>
<thead>
<tr>
<th>Managing type 2 diabetes (routine maintenance of a well-controlled condition)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Amount owed to providers:</strong> $5,400</td>
</tr>
<tr>
<td><strong>Plan pays</strong> $3,680</td>
</tr>
<tr>
<td><strong>Patient pays</strong> $1,720</td>
</tr>
</tbody>
</table>

**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 $20
- Copays $1,300
- Coinsurance $0
- Limits or exclusions $400

**Total** $1,720

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: AlabamaBlue.com.

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.
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.

Blue Cross and Blue Shield of Alabama is an independent licensee of the Blue Cross and Blue Shield Association.
Language Access Services and Notice of Nondiscrimination:
Blue Cross and Blue Shield of Alabama 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, 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.


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)


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)。


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


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


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。