BlueCross BlueShield of Alabama

Blue Value Gold

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 1-855-350-7437 or visit us at AlabamaBlue.com/bb/2025vgi.pdf**.** 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.org/sbcglossary or call 1-855-350-7437 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$750 / individual or $1,500 / family in-network. $1,500 / individual or $3,000 / 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 and drugs 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 $6,000 individual / $12,000 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 limits until the overall family out-of-pocket limits has been met.
What is not included in the out–of–pocket limit?	All out-of-network cost sharing amounts (deductibles, copays and coinsurance), premiums, balance-billing charges, healthcare this plan doesn't cover, and specialty drug coupon programs payments. Exceptions include out-of-network medical emergency services (including mental health and substance abuse) and out-of-network air ambulance services.	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.	You pay the least if you use a provider in the Hospital Choice Network Lower Member Cost Share tier. You pay more if you use a provider in the Hospital Choice Network Higher Member Cost Share tier. 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 Deductible does not apply	50% coinsurance	Member pays a $30 copay when visiting physicians other than their designated Primary Care Select physician; precertification is required for some provider administered drugs; if no precertification is obtained, no benefits are available
	Specialist visit	$45 copay/visit Deductible does not apply	50% coinsurance	Member pays a $60 copay when visiting a specialist not referred by their designated Primary Care Select physician; outside Alabama Specialist $120 copay; precertification is required for some provider administered drugs; if no precertification is obtained, no benefits are available
	Preventive care/screening/ immunization	No Charge Deductible does not apply	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 1-855-350-7437.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge Deductible does not apply	50% coinsurance	Benefits listed are physician services; some diagnostic tests and imaging may require precertification; if no precertification is obtained, no benefits are available; Lower Member Cost Share facilities subject to $300 copay; Higher Member Cost Share facilities subject to $600 copay; outside Alabama facilities subject to $800 copay; in Alabama out-of-network facilities not covered
	Imaging (CT/PET scans, MRIs)	$300 copay/visit Deductible does not apply	50% 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 drugs to treat your illness or condition More information about **prescription drug coverage** is available at **AlabamaBlue.com/2025SourcePlusRx1DrugList**	Tier 1 Drugs	$5 copay (retail) $12.50 copay (mail order) Deductible does not apply	Not Covered	Benefits listed are only available through the ValueONE Retail Network and the Home Delivery Network; precertification is required for some drugs; if no precertification is obtained, no benefits are available; covered insulin products may have lower patient responsibility; select generic specialty and biosimilar drugs on the Select Generic Specialty and Biosimilar Drug List will have lower member cost share.
	Tier 2 Drugs	$25 copay (retail) $62.50 copay (mail order) Deductible does not apply	Not Covered	
	Tier 3 Drugs	$55 copay (retail) $137.50 copay (mail order) Deductible does not apply	Not Covered	
	Tier 4 Drugs	40% coinsurance (retail) 40% coinsurance (mail order) Deductible does not apply	Not Covered	
	Tier 5 Drugs	$200 copay (retail) Deductible does not apply	Not Covered	
	Tier 6 Drugs	20% coinsurance (retail) Deductible does not apply	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Lower Member Cost Share $300 copay/visit Higher Member Cost Share $600 copay/visit Deductible does not apply	50% coinsurance	Outside Alabama, in-network copay is $800; in Alabama, out-of-network not covered; precertification may be required; if no precertification is obtained, no benefits are available
	Physician/surgeon fees	0% coinsurance	50% coinsurance	None
If you need immediate medical attention	Emergency room care	Accident: $300 copay/visit Deductible does not apply Medical Emergency: $300 copay/visit Deductible does not apply	Accident: $300 copay/visit Deductible does not apply Medical Emergency: $300 copay/visit Deductible does not apply	Physician charges will apply
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	$20 copay/visit Deductible does not apply	50% coinsurance	Member pays a $30 copay when visiting physicians other than their designated Primary Care Select physician

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 a hospital stay	Facility fee (e.g., hospital room)	Lower Member Cost Share $300 copay/day for days 1-5 Higher Member Cost Share $600 copay/day for days 1-5 Deductible does not apply	50% coinsurance	In Alabama, out-of-network benefits are only available for accidental injury and medical emergency; outside Alabama in-network 30% coinsurance; precertification is required; if no precertification is obtained, no benefits are available
	Physician/surgeon fees	0% coinsurance	50% coinsurance	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	$45 copay/visit Deductible does not apply	50% coinsurance Deductible does not apply	Member pays a $60 copay when visiting a specialist; outside Alabama Specialist $60 copay; facility services outside Alabama, in-network 30% coinsurance; precertification is required for intensive outpatient, partial hospitalization and inpatient hospitalization; if no precertification is obtained, no benefits are available
	Inpatient services	Physician: No Charge Deductible does not apply Inpatient Hospital: Lower Member Cost Share $300 copay/day for days 1-5 Higher Member Cost Share $600 copay/day for days 1-5 Deductible does not apply	Physician: 50% coinsurance Deductible does not apply Inpatient Hospital: 50% coinsurance	
If you are pregnant	Office visits	0% coinsurance	50% 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); facility services outside Alabama, in-network 30% coinsurance; precertification may be required for some inpatient services; if no precertification is obtained, no benefits are available
	Childbirth/delivery professional services	0% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	Lower Member Cost Share $300 copay/day for days 1-5 Higher Member Cost Share $600 copay/day for days 1-5 Deductible does not apply	50% 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	No Charge Deductible does not apply	50% coinsurance	Benefits for home infusion services are also available; precertification is required outside Alabama; if no precertification is obtained, no benefits are available; in Alabama, out-of-network not covered
	Rehabilitation services	20% coinsurance	50% coinsurance	30 visits per member per calendar year; includes occupational, physical and speech therapy; children ages 0-18 with an autistic diagnosis are allowed unlimited visits for occupational and speech therapy
	Habilitation services	20% coinsurance	50% coinsurance	30 visits per member per calendar year; includes occupational, physical and speech therapy; children ages 0-18 with an autistic diagnosis are allowed unlimited visits for occupational and speech therapy
	Skilled nursing care	Not Covered	Not Covered	Not covered; member pays 100%
	Durable medical equipment	20% coinsurance	50% coinsurance	Precertification may be required; if no precertification is obtained, no benefits are available
	Hospice services	No Charge Deductible does not apply	50% coinsurance	Precertification is required outside Alabama; if no precertification is obtained, no benefits are available; in Alabama, out-of-network not covered
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 Deductible does not apply	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; patient responsibility may vary

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 when necessary to prevent a serious health risk to the woman or as required by applicable laws)
- 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 (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- 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: 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 https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa or Blue Cross and Blue Shield of Alabama at 1-855-350-7437. 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: Alabama Department of Insurance at 1-334-269-3550 or Insdept@insurance.alabama.gov.

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? Not applicable

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)

The plan's overall deductible	$750
Specialist copayment	$45
Hospital (facility) copayment	$300
Other copayment/coinsurance	$300/20%

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	$750
Copayments	$600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$1,410

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$750
Specialist copayment	$45
Hospital (facility) copayment	$300
Other copayment/coinsurance	$300/20%

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	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$40
The total Joe would pay is	$740

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

The plan's overall deductible	$750
Specialist copayment	$45
Hospital (facility) copayment	$300
Other copayment/coinsurance	$300/20%

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	$750
Copayments	$400
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,350

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

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:

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 (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.

Blue Cross and Blue Shield of Alabama:

- 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: 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.

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 1-855-216-3144 (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 1-855-216-3144 (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 1-855-216-3144（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 1 855 216 3144 (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 +1 855 216 3144 (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. 1-855-216-3144 (TTY: 711) પર અથવા ગ્રાહક સેવા પર કૉલ કરો.

Hindi: ध्यान दें: अगर आप हिन्दी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायुता सेवाएँ उपलब्ध हैं। आसान प्रारूप में सूचना उपलब्ध कराने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 1-855-216-3144 (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。1-855-216-3144 (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. 1-855-216-3144(TTY: 711)로 전화하거나 고객 서비스에 문의하세요.

Lao: ເອົາໃຈໃສ່: ຖ້າເຈົ້າເວົ້າ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາຟຣີແມ່ນມີໃຫ້ທ່ານ. ການຊ່ວຍເຫຼືອ ແລະ ການບໍລິການທີ່ເໝາະສົມໃນການສະໜອງຂໍ້ມູນໃນຮູບແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້ແມ່ນຍັງສາມາດໃຊ້ໄດ້ໂດຍບໍ່ເສຍຄ່າ. ໂທ 1-855-216-3144 (TTY: 711) ຫຼື ໂທຫາຝ່າຍບໍລິການລູກຄ້າ.

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 1-855-216-3144 (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 1-855-216-3144 (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 1-855-216-3144 (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 1-855-216-3144 (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. 1-855-216-3144 (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 1-855-216-3144 (TTY: 711) hoặc gọi Dịch Vụ Khách Hàng.