BlueCross BlueShield of Alabama

# Blue Cross Select Silver, a Multi-State Plan

**Coverage Period: 01/01/2016 - 12/31/2016**

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs **Coverage For:** Individual + Family | **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.ibcbsal.com/bb/2016sms.pdf or by calling 1-855-350-7437.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | In-network: **$2,800** person **/ $5,600** family<br>Out-of-network: **$2,800** person **/ $5,600** family<br>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: $6,850** person **/ $13,700** 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 amounts (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. Each member must also designate a Primary Care Select physician to participate in the plan. | 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?** | Yes. Some services require a referral. | This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the specialist. |
| **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 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.

| 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 | $40 copay/visit | Not Covered | In Alabama, referral is required if services are not rendered by a Primary Care Select physician |
| | Specialist visit | $65 copay/visit | Not Covered | Referral is required in Alabama; outside of Alabama $130 copay |
| | Other practitioner office visit | 20% coinsurance for chiropractor | Not Covered | Subject to overall deductible; limited to 15 visits per member per calendar year |
| | Preventive care/ screening/immunization | No Charge | Not Covered | Please see AlabamaBlue.com/preventiveservices; in Alabama, referral is required if services are not rendered by a Primary Care Select physician; no referral needed for a vaccine administered at a pharmacy in the Pharmacy Vaccine Network |
| **If you have a test** | Diagnostic test (x-ray, blood work) | No Charge | Not Covered | Benefits listed are physician services; limited labs available in physician's office; in Alabama, in-network independent labs are through the Select Lab Network; outside Alabama, in-network subject to 20% coinsurance and overall deductible; if not precertification is obtained, no benefits are available |
| | Imaging (CT/PET scans, MRIs) | $350 copay per procedure | Not Covered | Benefits listed are physician services; outside Alabama, in-network subject to 20% coinsurance and overall deductible; some diagnostic tests and imaging may require precertification; if no precertification is obtained, no benefits are available |

| 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**<br><br>More information about **prescription drug coverage** is available at myprime.com/content/dam/prime/memberportal/forms/AuthorForms/IVL/2016/2016_AL_4T_Essential.pdf | Tier 1 drugs | Retail<br>$20 copay/30-day supply<br><br>PrimeMail® mail order $50 copay/90-day supply | Not Covered | Benefits listed are only available through the Limited Retail Network; generic drugs mandatory when available; precertification is required for some drugs; if precertification is not obtained, no coverage |
| | Tier 2 drugs | Retail<br>$65 copay/30-day supply<br><br>PrimeMail® mail order<br>$162.50 copay/90-day supply | Not Covered | Benefits listed are only available through the Limited Retail Network; generic drugs mandatory when available; precertification is required for some drugs; if precertification is not obtained, no coverage |
| | Tier 3 drugs | Retail<br>$100 copay/30-day Supply<br><br>PrimeMail® mail order<br>$250 copay/90-day supply | Not Covered | Benefits listed are only available through the Limited Retail Network; generic drugs mandatory when available; precertification is required for some drugs; if precertification is not obtained, no coverage |
| | Tier 4 drugs | Retail<br>20% coinsurance | Not Covered | Prime Therapeutics Specialty Pharmacy Network is the only in-network pharmacy for some Tier 4 (specialty drugs); specialty drugs can be dispensed for up to a 30-day supply; generic drugs mandatory when available; precertification is required for some drugs; if precertification is not obtained, no coverage |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance unless services are rendered in a Tier 1 hospital<br><br>Tier 1 hospital<br>$350 copay/visit | Not Covered | ——————none—————— |
| | Physician/surgeon fees | 0% coinsurance | Not Covered | Subject to overall deductible; referral is required in Alabama; |
| **If you need immediate medical attention** | Emergency room services | $350 copay/visit | $350 copay/visit | Subject to overall deductible for out-of-network; physician charges may apply |
| | Emergency medical transportation | 20% coinsurance | 50% coinsurance | Subject to overall deductible; benefits are available for air ambulance transportation, at no charge, to a network hospital of the member's choice near their home if hospitalized while traveling more than 150 miles from home; limited to 2 transports per member per calendar year |

| 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 |
|---|---|---|---|---|
| | Urgent care | $65 copay/visit | Not Covered | Referral is required in Alabama |
| **If you have a hospital stay** | Facility fee (e.g. hospital room) | 20% coinsurance unless services are rendered in a Tier 1 hospital<br><br>Tier 1 hospital $350 copay/day for days 1-5<br><br>$0 copay for days 6 and up | Not Covered | Precertification is required; if no precertification is obtained, no benefits are available |
| | Physician/surgeon fee | 0% coinsurance | Not Covered | Subject to overall deductible |
| **If you have mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | $65 copay/visit | Not Covered | Benefits listed are outpatient physician services and are available through the Blue Choice Behavioral Health Network or PPO physician; referral is required in Alabama; additional benefits are also available with higher patient responsibility; some services require precertification; if no precertification is obtained, no benefits are available |
| | Mental/Behavioral health inpatient services | No Charge | Not Covered | Benefits listed are inpatient physician services and are available through the Blue Choice Behavioral Health Network or PPO physician; additional benefits are also available with higher patient responsibility; precertification is required; if no precertification is obtained, no benefits are available |
| | Substance use disorder outpatient services | $65 copay/visit | Not Covered | Benefits listed are outpatient physician services and are available through the Blue Choice Behavioral Health Network or PPO physician; referral is required in Alabama; additional benefits are also available with higher patient responsibility; some services require precertification; if no precertification is obtained, no benefits are available |
| | Substance use disorder inpatient services | No Charge | Not Covered | Benefits listed are inpatient physician services and are available through the Blue Choice Behavioral Health Network or PPO physician; additional benefits are also available with higher patient responsibility; precertification is required; if no precertification is obtained, no benefits are available |
| **If you are pregnant** | Prenatal and postnatal care | 0% coinsurance | Not Covered | Subject to overall deductible; benefits listed are outpatient physician services |

| 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 | 0% coinsurance | Not Covered | Subject to overall deductible; benefits listed are inpatient physician services |
| **If you need help recovering or have other special health needs** | Home health care | 0% coinsurance | Not Covered | Subject to overall deductible; precertification is required; if no precertification is obtained outside of Alabama, no benefits are available |
| | Rehabilitation services | 20% coinsurance | Not Covered | Subject to overall deductible; limited to a combined maximum of 30 visits for occupational, physical and speech therapy per member per calendar year |
| | Habilitation services | 20% coinsurance | Not Covered | Subject to overall deductible; limited to a combined maximum of 30 visits for occupational, physical and speech therapy per member per calendar year |
| | Skilled nursing care | Not Covered | Not Covered | Not covered; member pays 100% |
| | Durable medical equipment | 20% coinsurance | Not Covered | Subject to overall deductible |
| | Hospice service | 0% coinsurance | Not Covered | Subject to overall deductible; precertification is required; if no precertification is obtained outside of Alabama, no benefits are available |
| **If your child needs dental or eye care** | Eye exam | 20% coinsurance | Not Covered | 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 |
| | 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; subject to overall deductible |
| | Dental check-up | No Charge | Not Covered | Benefits include diagnostic and preventive services for members up to the end of the month in which the member turns 19; limited to 2 visits per year; additional benefits available; limitations apply; patient responsibility may vary |

## 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)
- Elective abortion
- 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 1-800-292-8868. You may also contact your state insurance department at 334-241-4192 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 334-241-4192 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.**

## Language Access Services:

SPANISH (Español): Para obtener asistencia en Español, llame al 1-855-350-7437.

*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** $3,840
- **Patient pays** $3,700

**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 | $2800 |
| Copays | $700 |
| Coinsurance | $0 |
| Limits or exclusions | $200 |
| **Total** | **$3,700** |

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.

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,280
- **Patient pays** $2,120

**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 | $1,700 |
| Coinsurance | $0 |
| Limits or exclusions | $400 |
| **Total** | **$2,120** |

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.

# 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.