



AlabamaBlue.com. 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 www.bcbsal.org/sbcglossary/ or call 1-800-292-8868 to request a copy.

Important Questions

Will you pay less if you <u>_____</u> ?	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	\$15 copay /visit No overall deductible	\$20 copay /visit	In Alabama, out-of-network coinsurance is 50%
	Specialist visit	\$15 copay /visit No overall deductible	\$20 copay /visit	
	Preventive care/screening/immunization	No Charge No overall deductible	Not Covered	Please visit AlabamaBlue.com/preventiveservices . You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	30% coinsurance	Benefits listed are physician services; in Alabama, out-of-network coinsurance is 50%; facility benefits are also available; precertification may be required
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at AlabamaBlue.com/pharmacy	Tier 1 Drugs	\$5 copay (retail) \$12.50 copay (mail order) No overall deductible	Not Covered	Prior authorization required for specific drugs; 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	\$5 copay (retail) \$12.50 copay (mail order) No overall deductible	Not Covered	
	Tier 3 Drugs	\$25 copay (retail) \$62.50 copay (mail order) No overall deductible	Not Covered	
	Tier 4 Drugs	\$40 copay (retail) \$100 copay (mail order) No overall deductible	Not Covered	
	Tier 5 Drugs (preferred specialty)	\$80 copay (retail)		

* For more information about limitations and exceptions, see the plan or policy document at [AlabamaBlue.com](#).

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 immediate medical attention	Emergency room care	Accident: \$200 copay /visit No overall deductible Medical Emergency: \$200 copay /visit No overall deductible	Accident: \$200 copay /visit No overall deductible Medical Emergency: \$200 copay /visit No overall deductible	Physician charges will apply
	Emergency medical transportation	No Charge No overall deductible	No Charge No overall deductible	None
	Urgent care	\$15 copay /visit No overall deductible	\$20 copay /visit	In Alabama, out-of-

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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	10% coinsurance	30% coinsurance	In Alabama, out-of-network not covered; benefits are also available for home infusion services; precertification may be required Benefits listed are for Rehabilitation & Habilitation services; each service has a combined maximum of 30 visits for
	Rehabilitation services	10% coinsurance	30% coinsurance	

* For more information about limitations and exceptions, see the plan or policy document at AlabamaBlue.com.

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 .)		
• Acupuncture	• Hearing aids	• Routine foot care
• Bariatric surgery	• Long-term care	• Weight loss programs
• Cosmetic surgery	• Private-duty nursing	
• Dental care (Adult)	• Routine eye care (Adult)	

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Chiropractic care	• 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 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

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	\$150
Specialist copay/coinsurance	\$15/0%
Hospital (facility)	
copay/coinsurance	\$0/10%
Other copay/coinsurance	\$200/10%

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

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*)

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.