BlueCross BlueShield of Alabama

Individual + Family HDHP

For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-239-5772 or visit us at 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.

	$1,500 self only coverage/$3,000 family coverage.	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, the overall family deductible must be met before the plan begins to pay.
	Yes. Preventive services in-network 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/.
		is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.
	Premiums, balance-billed charges, health care this plan doesn't cover, cost sharing for most out-of-network benefits and pre-certification penalties.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
	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--

All ________ and ________ costs shown in this chart are after your ________ has been met, if a ________ applies.

________	Primary care visit to treat an injury or illness	20% coinsurance	40% coinsurance	In Alabama, out-of-network coinsurance is 50%
	Specialist visit	20% coinsurance	40% coinsurance	
	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.
	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	Benefits listed are physician services; in Alabama, out-of-network coinsurance is 50%; facility benefits are also available;

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	Home health care	20% coinsurance	40% coinsurance	In Alabama, out-of-network not covered; benefits are also available for home infusion services; precertification may be required
	Rehabilitation services	20% coinsurance	40% coinsurance	Benefits listed are for Rehabilitative and Habilitative services; each service has a maximum of 35 visits per therapy for occupational, physical and speech therapy per member per calendar year
	Habilitation services	20% coinsurance	40% coinsurance	
	Skilled nursing care	Not Covered	Not Covered	Not covered; member pays 100%
	Durable medical equipment	20% coinsurance	40% coinsurance	None
	Hospice services	20% coinsurance	40% coinsurance	In Alabama, out-of-network not covered; precertification may be required
	Children's eye exam	No Charge No overall deductible	Not Covered	Please visit AlabamaBlue.com/preventiveservices
	Children's glasses	Not Covered	Not Covered	Not covered; member pays 100%
	Children's dental check-up	No Charge No overall deductible	Not Covered	Please visit AlabamaBlue.com/preventiveservices

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Glasses, child
- Hearing aids
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Skilled nursing care
- Weight loss programs

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• Bariatric surgery (only for morbid obesity in limited circumstances) • Chiropractic care (limited to 24 visits per member per calendar year) • Infertility treatment (Assisted Reproductive Technology not covered) • Non-emergency care when traveling outside the U.S.

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.

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.

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.

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.~~

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(9 months of in-network pre-natal care and a hospital delivery)	(a year of routine in-network care of a well-controlled condition)	(in-network emergency room visit and follow up care)

The ____ would be responsible for the other costs of these EXAMPLE covered services.