City of Montgomery-BlueCard PPO Plan Actives

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 334-625-2674 or visit us at www.montgomeryal.gov. 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.

Monthly Premium Costs to Employee: Individual - $166 Family - $366

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$300 individual/$900 family.	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. 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/.
Are there other deductibles for specific services?	Yes. $300 per admission. $500 per admission for out-of-network. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out–of–pocket limit for this plan?	$2500 individual/$5000 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 limit until the overall family out-of-pocket limit has been met.
What is not included in the out–of–pocket limit?	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.
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.	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	$50 copay/visit No overall deductible	35% coinsurance	None
	Specialist visit	$60 copay/visit No overall deductible	35% coinsurance	
	Preventive care/screening/ immunization	No Charge No overall deductible	Not Covered	Please visit AlabamaBlue.com/preventiveservices; additional services are available. You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive.Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	35% coinsurance	Benefits listed are physician services; facility benefits are also available; precertification may be required
	Imaging (CT/PET scans, MRIs)	No Charge	35% coinsurance	
If you need drugs to treat your illness or condition Coverage administered through EHO (Employer Health Options) 1-800-650-1817.	Tier 1 Drugs	$10 copay	$10 copay	The first prescription for pain killers and sleep aids will be filled for a 14-day supply after which a protocol form must be completed by your doctor and sent to EHO. Some medications may require "Prior-Authorization". This form can be obtained from EHO.
	Tier 2 Drugs	25% copay	25% copay	
	Tier 3 Drugs	25% copay plus $20 fee	25% copay plus $20 fee	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$175 copay No overall deductible	35% coinsurance	None
	Physician/surgeon fees	No Charge No overall deductible	35% coinsurance	None
If you need immediate medical attention	Emergency room care	Accident: No Charge No overall deductible Medical Emergency: $150 copay/visit No overall deductible	Accident: No Charge No overall deductible Medical Emergency: $150 copay/visit	Physician charges will apply

* For more information about limitations and exceptions, see the plan or policy document at www.montgomeryal.gov

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)	
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	$60 copay/visit No overall deductible	35% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$300 per admission deductible & $60 copay/day days 2-5 No overall deductible	$500 per admission deductible & 35% coinsurance No overall deductible	In Alabama, out-of-network benefits are only available for accidental injury; precertification is required
	Physician/surgeon fees	No Charge No overall deductible	35% coinsurance	None

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 mental health, behavioral health, or substance abuse services Coverage administered through American Behavioral 1-800-677-4544	Mental/Behavioral Health Outpatient Services Includes the following: • Outpatient office visits • Psychological/Neuropsychological Testing	• Visits 1-5: $5 copay per visit • Visits 6-20: $20 copay per visit • Visits 21-30: $35 copay per visit	50% of the standard rate set by American Behavioral and any billed charges not covered by the plan	Up to 30 visits / sessions / group therapy sessions (or any combination thereof) total, for outpatient mental health treatment each contract year. Psychological/neuropsychological testing requires pre-authorization. Call 1-800-677-4544
	Mental/Behavioral Health Inpatient Services Includes the following: • Acute Inpatient Hospitalization • Partial Hospitalization / Day Treatment Program (PHP) • Electroconvulsive Therapy (ECT)	• Days 1-3: $100 per day copay • Days 4-19: Full coverage • Days 20-30: $25 per day copay	50% of the standard rate set by American Behavioral and any billed charges not covered by the plan	Up to 30 days total for inpatient mental health treatment each contract year; 60 days per lifetime. All inpatient services require pre-authorization. Call 1-800-677-4544
	Inpatient Physician Services In Conjunction With an Approved Inpatient Hospitalization	No Charge	50% of the standard rate set by American Behavioral and any billed charges not covered by the plan	Up to 30 days total for inpatient mental health treatment each contract year; 60 days per lifetime
	Anesthesia in Conjunction with ECT Treatment	20% of the standard rate set by American Behavioral	20% of the standard rate set by American Behavioral and any billed charges not covered by the plan	Up to 30 days total for inpatient mental health treatment each contract year; 60 days per lifetime
	Substance Use Disorder Outpatient Services	$150 per admission deductible	Not Covered	Based on appropriate level of care and medical necessity criteria
If you are pregnant	Office visits	No Charge No overall deductible	35% coinsurance	
	Childbirth/delivery professional services	No Charge No overall deductible	35% 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)	
	Childbirth/delivery facility services	$300 per admission deductible & $60 copay/day days 2-5 No overall deductible	$500 per admission deductible & 35% coinsurance No overall deductible	Cost sharing does not apply to certain 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)
If you need help recovering or have other special health needs	Home health care	No Charge No overall deductible	35% coinsurance	In Alabama, out-of-network not covered; precertification may be required
	Rehabilitation services	20% coinsurance	20% coinsurance	Benefits listed are for occupational and physical therapy; occupational therapy is limited to certain services related to hand and lymphedema; speech therapy is not covered
	Habilitation services	20% coinsurance	20% coinsurance	
	Skilled nursing care	Not Covered	Not Covered	Not covered; member pays 100%
	Durable medical equipment	20% coinsurance	20% coinsurance	None
	Hospice services	No Charge No overall deductible	35% coinsurance	In Alabama, out-of-network not covered; precertification may be required
If your child needs dental or eye care	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

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
- Cosmetic surgery
- Glasses, child
- 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.)	
• Bariatric surgery (only for morbid obesity in limited circumstances)	• Infertility treatment (Assisted Reproductive Technology not covered)
• Chiropractic care	• 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 Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323 x61565 or www.cciio.cms.gov. If coverage is insured, contact your State insurance regulator regarding your possible rights to continuation coverage under State Law. 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 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: Blue Cross and Blue Shield of Alabama at 1-800-828-6451.

Does this plan provide Minimum Essential Coverage? **Yes**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? **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.

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	$300
Specialist copay/coinsurance	$60/0%
Hospital (facility) copay/coinsurance	$60/0%
Other copay/coinsurance	$60/20%

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	$12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles*	$300
Copayments	$360
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$720

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

The plan's overall deductible	$300
Specialist copay/coinsurance	$60/0%
Hospital (facility) copay/coinsurance	$60/0%
Other copay/coinsurance	$60/20%

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	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$300
Copayments	$120
Coinsurance	$0
What isn't covered	
Limits or exclusions	$420
The total Joe would pay is	$840

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

The plan's overall deductible	$300
Specialist copay/coinsurance	$60/0%
Hospital (facility) copay/coinsurance	$60/0%
Other copay/coinsurance	$60/20%

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	$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$300
Copayments	$180
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$580

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 call 334-625-3692.
*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

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

Language Access Services and Notice of Nondiscrimination only apply to administrative services that Blue Cross and Blue Shield of Alabama provides to your employer.

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, 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.

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)

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-216-3144 (TTY: 711)번으로 전화해 주십시오.

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）。

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-216-3144 (TTY: 711).

Arabic: انتباه: إذا كنت تتحدث العربية، توجد خدمات مساعدة فيما يتعلق باللغة، بدون تكلفة، متاحة لك. اتصل ب1-855-216-3144 (الهاتف النصي: 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-216-3144 (TTY: 711).

French: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-216-3144 (ATS: 711).

French Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-855-216-3144 (TTY: 711).

Gujarati: ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હોય, તો ભાષા સહાયતા સેવા, તમારા માટે નિઃશુલ્ક ઉપલબ્ધ છે. 1-855-216-3144 પર કૉલ કરો (TTY: 711).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-216-3144 (TTY: 711).

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

Laotian: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-855-216-3144 (TTY: 711).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-216-3144 (телетайп: 711).

Portuguese: ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-855-216-3144 (TTY: 711).

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-855-216-3144 (TTY: 711).

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

Italian: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-216-3144 (TTY: 711).

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。