




Blue Cross Select Silver: Limited Cost-Sharing 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/2022css-limited.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? | \$3,700 individual/\$7,400 family in-network. \$7,400 individual/\$14,800 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 \$8,150 individual/\$16,300 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? | All out-of-network cost sharing amounts (deductibles, copays and coinsurance) except out-of-network mental health disorders & substance abuse medical emergency services; except out-of-network medical emergency services and out-of-network air ambulance services; premiums, balance-billed charges and healthcare this plan doesn't cover. | 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. All covered benefits rendered directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under referral/purchased health services program are covered at 100% of the allowed amount, with no copayments, deductibles or coinsurance | The Hospital Choice Network evaluates cost, quality and patient experience in member hospitals. Hospitals are categorized as either Lower Member Cost Share or Higher Member Cost Share, based on their performance. 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? | 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. |



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 | \$40 copay /visit No overall deductible | Not Covered | Members are required to designate a Primary Care Select physician; in Alabama, referral is required if services are not rendered by a Primary Care Select physician |
| | Specialist visit | \$65 copay /visit No overall deductible | 50% coinsurance | Referral is required in Alabama; outside Alabama, in-network subject to \$130 copay |
| | Preventive care/screening/immunization | No Charge No overall deductible | 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. In Alabama, you must receive these services by your Primary Care Select physician or be referred by your Primary Care Select physician (except services at an Urgent Care Choice provider for immunizations rendered by a pharmacy in the Pharmacy Vaccine Network). 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 No overall deductible | 50% coinsurance | Benefits listed are physician services; outside Alabama, in-network subject to 20% coinsurance and overall deductible; some diagnostic test and imaging may require precertification; if no precertification is obtained, no benefits are available |
| | Imaging (CT/PET scans, MRIs) | \$600 copay /visit No overall deductible | 50% coinsurance | Benefits listed are physician services; outside Alabama in-network \$900 copay/visit; some diagnostic tests and imaging may require precertification; if no precertification is obtained, no benefits are available |

* For more information about limitations and exceptions, see the plan or policy document at [AlabamaBlue.com/bb/2022css-limited.pdf](#)

| 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/2022SourcePlusRx1DrugList | Tier 1 Drugs | \$20 copay (retail) \$50 copay (mail order) No overall deductible | Not Covered | Benefits listed are only available through the ValueONE Network; precertification is required for some drugs; if no precertification is obtained, no benefits are available; covered insulin products may have lower patient responsibility |
| | Tier 2 Drugs | \$30 copay (retail) \$75 copay (mail order) No overall deductible | Not Covered | |
| | Tier 3 Drugs | \$85 copay (retail) \$212.50 copay (mail order) No overall deductible | Not Covered | |
| | Tier 4 Drugs | 50% coinsurance (retail) 50% coinsurance (mail order) No overall deductible | Not Covered | |
| | Tier 5 Drugs (preferred specialty) | \$250 copay (retail) No overall deductible | Not Covered | |
| | Tier 6 Drugs (non-preferred specialty) | 30% coinsurance (retail) No overall deductible | Not Covered | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | Lower Member Cost Share \$600 copay /visit Higher Member Cost Share \$1,000 copay /visit No overall deductible | 50% coinsurance | Outside Alabama, in-network copay is \$1,200; in Alabama, out-of-network not covered; precertification may be required |
| | Physician/surgeon fees | 0% coinsurance | 50% coinsurance | Outside Alabama, in-network 20% coinsurance; referral is required in Alabama |
| If you need immediate medical attention | Emergency room care | Accident: \$600 copay /visit No overall deductible Medical Emergency: \$600 copay /visit No overall deductible | Accident: \$600 copay /visit No overall deductible Medical Emergency: \$600 copay /visit No overall deductible | Physician charges will apply |
| | Emergency medical transportation | 20% coinsurance | 20% coinsurance | None |
| | Urgent care | \$40 copay /visit No overall deductible | 50% coinsurance | In Alabama, referral is required unless services are rendered by an Urgent Care Choice provider after hours (6 pm through 7 am), weekends (Friday 6pm through Monday 7am) and certain Federal holidays |

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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 have a hospital stay | Facility fee (e.g., hospital room) | Lower Member Cost Share 20% coinsurance Higher Member Cost Share 25% coinsurance No overall deductible | 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 | \$65 copay /visit No overall deductible | 50% coinsurance No overall deductible | Benefits listed are physician services; referral is required in Alabama; outside Alabama in-network \$65 copay; precertification is required for intensive outpatient, partial hospitalization and inpatient hospitalization |
| | Inpatient services | No Charge No overall deductible | 50% coinsurance No overall deductible | |
| 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); facilities outside Alabama in-network 30% coinsurance |
| | Childbirth/delivery professional services | 0% coinsurance | 50% coinsurance | |
| | Childbirth/delivery facility services | Lower Member Cost Share 20% coinsurance Higher Member Cost Share 25% coinsurance No overall deductible | 50% coinsurance | |

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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 | 0% coinsurance | 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 | None |
| | Hospice services | 0% coinsurance | 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 No overall deductible | 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 |

* For more information about limitations and exceptions, see the plan or policy document at AlabamaBlue.com/bb/2022css-limited.pdf

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 .) | | |
|---|--|--|
| <ul style="list-style-type: none">• Abortion (except in cases of rape, incest, or when the life of the mother is endangered)• Acupuncture• Bariatric surgery• Cosmetic surgery | <ul style="list-style-type: none">• Dental care (Adult)• Hearing aids• Long-term care• Private-duty nursing | <ul style="list-style-type: none">• 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.) | | |
| <ul style="list-style-type: none">• Chiropractic care (limited to 15 visits per member per calendar year) | <ul style="list-style-type: none">• Infertility treatment (Assisted Reproductive Technology not covered) | <ul style="list-style-type: none">• 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 [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: 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) | | 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) | |
|---|-----------------|---|----------------|--|----------------|
| ■ The plan's overall deductible | \$3,700 | ■ The plan's overall deductible | \$3,700 | ■ The plan's overall deductible | \$3,700 |
| ■ Specialist copay/coinsurance | \$65/0% | ■ Specialist copay/coinsurance | \$65/0% | ■ Specialist copay/coinsurance | \$65/0% |
| ■ Hospital (facility) copay/coinsurance | \$0/20% | ■ Hospital (facility) copay/coinsurance | \$0/20% | ■ Hospital (facility) copay/coinsurance | \$0/20% |
| ■ Other copay/coinsurance | \$600/20% | ■ Other copay/coinsurance | \$600/20% | ■ Other copay/coinsurance | \$600/20% |
| <p>This EXAMPLE event includes services like: Specialist office visits (<i>prenatal care</i>) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests (<i>ultrasounds and blood work</i>) Specialist visit (<i>anesthesia</i>)</p> | | <p>This EXAMPLE event includes services like: Primary care physician office visits (<i>including disease education</i>) Diagnostic tests (<i>blood work</i>) Prescription drugs Durable medical equipment (<i>glucose meter</i>)</p> | | <p>This EXAMPLE event includes services like: Emergency room care (<i>including medical supplies</i>) Diagnostic tests (<i>x-ray</i>) Durable medical equipment (<i>crutches</i>) Rehabilitation services (<i>physical therapy</i>)</p> | |
| Total Example Cost | \$12,700 | Total Example Cost | \$5,600 | Total Example Cost | \$2,800 |
| In this example, Peg would pay: | | In this example, Joe would pay: | | In this example, Mia would pay: | |
| <i>Cost Sharing</i> | | <i>Cost Sharing</i> | | <i>Cost Sharing</i> | |
| Deductibles | \$3,700 | Deductibles | \$200 | Deductibles | \$1,900 |
| Copayments | \$10 | Copayments | \$900 | Copayments | \$500 |
| Coinsurance | \$1,500 | Coinsurance | \$0 | Coinsurance | \$0 |
| <i>What isn't covered</i> | | <i>What isn't covered</i> | | <i>What isn't covered</i> | |
| Limits or exclusions | \$60 | Limits or exclusions | \$40 | Limits or exclusions | \$0 |
| The total Peg would pay is | \$5,270 | The total Joe would pay is | \$1,140 | The total Mia would pay is | \$2,400 |

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 Access 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. 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 بـ 1-855-216-3144 (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 નિ:શુલ્ક ઉપલબ્ધ છે. 1-855-216-3144 પર કોલ 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 नि:शुल्क उपलब्ध हैं। 1-855-216-3144 (TTY: 711) पर कॉल करें।

Laotian: ໂບດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 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 yardımını 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。