Imperial Electric - Union PPO

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 1-800-783-2197 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.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$250 / individual or $500 / family in-network. $500 / individual or $1,000 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. 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?	No.	You don't have to meet deductible for specific services.
What is the out–of–pocket limit for this plan?	For in-network $1,100 individual / $2,200 family. For out-of-network $2,200 individual / $4,400 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-billing charges, health care this plan doesn't cover 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	$10 copay/visit Deductible does not apply	30% coinsurance	Precertification is required for some provider administered drugs; if no precertification is obtained, no benefits are available
	Specialist visit	$10 copay/visit Deductible does not apply	30% coinsurance	
	Preventive care/screening/ immunization	No Charge Deductible does not apply	30% coinsurance	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 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; facility benefits are also available; precertification may be required; if no precertification is obtained, no benefits are available
	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 www.caremark.com 800.552.8159	Tier 1 Drugs	20% coinsurance (retail) 20% coinsurance (mail order) Deductible does not apply	20% coinsurance (retail) Deductible does not apply	Pharmacy Coverage is provided by CVS Caremark. Certain drugs may require pre-authorization. In addition, you may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. Please note not all drugs are covered. You will need to obtain certain drugs, specialty medications, from a pharmacy designated by CVS Caremark. Preventive drugs based on the preventive drug list are covered at 100% of the allowed amount, no copay for each 30-day prescription. Drugs on the Pharma Copayment Assistance Program List are subject to the greater of the applicable tier copay or the full amount of the available manufacturer cost share assistance program payments.
	Tier 2 Drugs	20% coinsurance (retail) 20% coinsurance (mail order) Deductible does not apply	20% coinsurance (retail) Deductible does not apply	
	Tier 3 Drugs	20% coinsurance (retail) 20% coinsurance (mail order) Deductible does not apply	20% coinsurance (retail) Deductible does not apply	
	Tier 4 Drugs	20% coinsurance (retail) Deductible does not apply	20% coinsurance (retail) Deductible does not apply	

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 outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	Precertification may be required; if no precertification is obtained, no benefits are available
	Physician/surgeon fees	10% coinsurance	30% coinsurance	None
If you need immediate medical attention	Emergency room care	Accident: 10% coinsurance Medical Emergency: 10% coinsurance	Accident: 10% coinsurance Medical Emergency: 10% coinsurance	Physician charges will apply; subject to in-network overall deductible
	Emergency medical transportation	10% coinsurance	10% coinsurance	None
	Urgent care	$10 copay/visit	$10 copay/visit	Benefits listed are Urgent Care Facility or Outpatient Facility; copay waived if admitted
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	In Alabama, out-of-network benefits are only available for accidental injury and medical emergency; precertification is required; if no precertification is obtained, no benefits are available
	Physician/surgeon fees	10% coinsurance	30% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$10 copay/visit Deductible does not apply	30% coinsurance	Precertification is required for intensive outpatient, partial hospitalization and inpatient hospitalization; if no precertification is obtained, no benefits are available
	Inpatient services	10% coinsurance	30% coinsurance	
If you are pregnant	Office visits	No Charge Deductible does not apply	30% 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); precertification may be required for some inpatient services; if no precertification is obtained, no benefits are available
	Childbirth/delivery professional services	10% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	30% 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)	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	30% coinsurance	Precertification is required; if no precertification is obtained, no benefits are available; benefits are also available for home infusion services
	Rehabilitation services	$10 copay/visit Deductible does not apply	30% coinsurance	Benefits listed are for Rehabilitation and Habilitation services; limited to a maximum of 60 visits/year for each therapy; includes occupational, physical and speech therapy; age limits do not apply; no age or visit limits for Autism Spectrum Disorders
	Habilitation services	$10 copay/visit Deductible does not apply	30% coinsurance	
	Skilled nursing care	10% coinsurance	30% coinsurance	Precertification is required; if no precertification is obtained, no benefits are available
	Durable medical equipment	10% coinsurance	30% coinsurance	Precertification may be required; if no precertification is obtained, no benefits are available
	Hospice services	10% coinsurance	30% coinsurance	Precertification is required, if no precertification is obtained, no benefits are available; services must be authorized by a physician
If your child needs dental or eye care	Children's eye exam	Not covered except as required by Health Care Reform	Not covered except as required by Health Care Reform	Please visit AlabamaBlue.com/PreventiveServices; 30% subject to overall deductible for out-of-network
	Children's glasses	Not Covered	Not Covered	Not covered; member pays 100%
	Children's dental check-up	Not covered except as required by Health Care Reform	Not covered except as required by Health Care Reform	Please visit AlabamaBlue.com/PreventiveServices; 60% subject to overall deductible for out-of-network services

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.)		
• Cosmetic surgery	• Hearing aids	• Routine foot care
• Dental care (Adult)	• Long-term care	• Weight loss programs
• Glasses, child	• Routine eye care (Adult)	

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture (limitations may apply)	• Chiropractic care (limitations apply)	• Non-emergency care when traveling outside the U.S.
• Bariatric surgery (limitations apply)	• Infertility treatment (Assisted Reproductive Technology not covered)	

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 http://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa or your plan administrator at the phone number listed in your benefit booklet. 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 on how 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 http://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa.

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? **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	$250
Specialist copay	$10
Hospital (facility) coinsurance	10%
Other copay/coinsurance	$10/20%

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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$250
Copayments	$0
Coinsurance	$850
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$1,160

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

The plan's overall deductible	$250
Specialist copay	$10
Hospital (facility) coinsurance	10%
Other copay/coinsurance	$10/20%

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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$250
Copayments	$60
Coinsurance	$790
What isn't covered	
Limits or exclusions	$40
The total Joe would pay is	$1,140

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

The plan's overall deductible	$250
Specialist copay	$10
Hospital (facility) coinsurance	10%
Other copay/coinsurance	$10/20%

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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$250
Copayments	$60
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$510

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.

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 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。