



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, contact Jackson Hospital Human Resources. 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 ?	Jackson Hospital or Jackson Hospital Providers: \$750 / individual in-network Other PPO Providers: \$2,000 / individual in-network. \$4,000 / individual 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 ?	\$8,000 individual / \$12,000 family.	The out-of-pocket limits 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 limits 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, cost sharing for most out-of-network benefits, pre-certification penalties, prescription drugs and specialty drug manufacturer assistance amounts for provider -administered drugs	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	\$40 copay /visit Deductible does not apply (Jackson Hospital)	50% coinsurance	\$50 primary care copay or \$80 specialist copay for non-Jackson Hospital physicians; precertification is required for some provider -administered drugs; if no precertification is obtained, no benefits are available
	Specialist visit	\$40 copay /visit Deductible does not apply (Jackson Hospital)	50% coinsurance	
	Preventive care/screening/immunization	No Charge Deductible does not apply	Not Covered	
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance Deductible does not apply (Jackson Hospital)	50% coinsurance	Benefits listed are physician services ; 30% coinsurance with no deductible for non-Jackson Hospital physician. Advanced Imaging services subject to 30% coinsurance & \$500 copay per visit with a non-Jackson Hospital physician, deductible does not apply; facility benefits also available; precertification may be required; if no precertification is obtained, no benefits are available
	Imaging (CT/PET scans, MRIs)	20% coinsurance Deductible does not apply (Jackson Hospital)	50% coinsurance	
If you need drugs to treat your illness or condition	Tier 1 Drugs	30 day - \$15 / 90 day - \$37.50	Not Covered	Prescription benefits are administered by Jackson Apothecary. Specialty medication through Jackson Apothecary is \$150 copay for 30 day supply.
	Tier 2 Drugs	30 day - \$40 / 90 day - \$100	Not Covered	
	Tier 3 Drugs	30 day - \$60 / 90 day - \$150	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$100 copay & 20% coinsurance Deductible does not apply (Jackson Hospital) \$100 copay & 30% Deductible does not apply (other in-network hospitals when services cannot be rendered at Jackson Hospital)	50% coinsurance	Services that can be performed at Jackson Hospital but are not, 30% coinsurance and subject to a \$3,000 copay per visit; deductible does not apply; in Alabama, out-of-network not covered; precertification may be required; if no precertification is obtained, no benefits are available

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)	
	Physician/surgeon fees	20% coinsurance Deductible does not apply (Benefits listed are Jackson Hospital physicians (Active and Courtesy physician when services are provided at Jackson Hospital))	50% coinsurance	Non-Jackson Hospital physician; 30% coinsurance , deductible does not apply
If you need immediate medical attention	Emergency room care	Accident: \$150 copay /visit & 20% coinsurance Deductible does not apply (Jackson Hospital) Medical Emergency: \$150 copay /visit 20% coinsurance Deductible does not apply (Jackson Hospital)	Accident: \$250 copay /visit & 20% coinsurance Deductible does not apply Medical Emergency: \$250 copay /visit & 20% coinsurance Deductible does not apply	Physician charges will apply; non-Jackson Hospitals and providers 30% coinsurance after \$250 facility copay , deductible does not apply
	Emergency medical transportation	30% coinsurance	30% coinsurance	None
	Urgent care	\$25 copay /visit Deductible does not apply (Jackson Clinic)	\$100 copay /visit Deductible does not apply	\$100 copay for non-Jackson Hospital physicians
If you have a hospital stay	Facility fee (e.g., hospital room)	\$250 copay & 20% coinsurance Deductible does not apply \$250 copay & 30% coinsurance (Other in-network hospitals when services cannot be rendered at Jackson Hospital)	50% coinsurance	Services that can be rendered at Jackson Hospital but are performed at another in-network facility 30% coinsurance subject to \$3,000 per admission deductible ; in Alabama, out-of-network only available for accidental injury and medical emergency; precertification is required; if no precertification is obtained, no benefits are available
	Physician/surgeon fees	20% coinsurance Deductible does not apply (Jackson Hospital)	50% coinsurance	30% coinsurance for non-Jackson Hospital physicians, 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 need mental health, behavioral health, or substance abuse services	Outpatient services	\$40 copay /visit Deductible does not apply	50% coinsurance	30% coinsurance , deductible does not apply for other inpatient PPO physicians; additional benefits are available; precertification is required for intensive outpatient, partial hospitalization and inpatient hospitalization ; if no precertification is obtained, no benefits are available
	Inpatient services	20% coinsurance Deductible does not apply	Physician: 20% coinsurance Deductible does not apply Inpatient Hospital: 50% coinsurance	
If you are pregnant	Office visits	20% coinsurance Deductible does not apply Jackson Hospital physicians (Active and Courtesy physicians when services are provided at Jackson Hospital)	50% coinsurance	Cost sharing does not apply for preventive services . Depending on the type of services, copayment , coinsurance or deductible may apply; Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound); 30% coinsurance for Non-Jackson Hospital physicians; services that can be rendered at Jackson Hospital but are performed at another in-network facility 30% coinsurance subject to \$3,000 per admission deductible ; precertification may be required for some inpatient services; if no precertification is obtained, no benefits are available
	Childbirth/delivery professional services	20% coinsurance Deductible does not apply Jackson Hospital physicians (Active and Courtesy physicians when services are provided at Jackson Hospital)	50% coinsurance	
	Childbirth/delivery facility services	\$250 copay & 20% coinsurance Deductible does not apply \$250 copay & 30% coinsurance (Other in-network hospitals when services cannot be rendered at Jackson Hospital)	50% 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	30% coinsurance Deductible does not apply	Not covered; member pays 100% (non-preferred Home Health in Alabama)	30% coinsurance , deductible does not apply non-preferred Home Health outside Alabama, precertification may be required; if no precertification is obtained; no benefits are available; benefits are also available for home infusion services
	Rehabilitation services	30% coinsurance for physical therapy (Jackson Hospital physician) 50% coinsurance for other PPO Physicians	30% coinsurance for physical therapy (Jackson Hospital physician) 50% coinsurance for other PPO Physicians	Benefits listed are for physical therapy; occupational and speech therapy subject to 30% coinsurance and overall deductible
	Habilitation services	30% coinsurance for physical therapy (Jackson Hospital physician) 50% coinsurance for other PPO Physicians	0% coinsurance for physical therapy 50% coinsurance for other PPO Physicians	
	Skilled nursing care	Not Covered	Not Covered	
	Durable medical equipment	30% coinsurance (Jackson Hospital/ MedSouth providers)	30% coinsurance (Jackson Hospital/ MedSouth providers)	Non-Jackson/MedSouth suppliers 50% coinsurance ; orthopedic supplies 30% coinsurance for any in-network provider ; precertification may be required; if no precertification is obtained; no benefits are available
	Hospice services	30% coinsurance Deductible does not apply	Not covered; member pays 100% (non-preferred Hospice in Alabama)	30% coinsurance , deductible does not apply non-preferred Hospice outside Alabama, precertification is required; if no precertification is obtained; no benefits are available; benefits are also available for home infusion services
If your child needs dental or eye care	Children's eye exam	No Charge Deductible does not apply	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 Deductible does not apply	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 • 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
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) • Chiropractic care (Limited to 15 visits per member per calendar year)	• 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 <https://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 <https://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	\$750
■ Specialist copayment	\$40
■ Hospital (facility) copayment/coinsurance	\$250/20%
■ Other copayment/coinsurance	\$150/30%

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
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$300
Coinsurance	\$2,500
What isn't covered	
Limits or exclusions	\$70
The total Peg would pay is	\$2,870

Managing Joe's Type 2 Diabetes

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

■ The plan's overall deductible	\$750
■ Specialist copayment	\$40
■ Hospital (facility) copayment/coinsurance	\$250/20%
■ Other copayment/coinsurance	\$150/30%

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
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$200
Copayments	\$200
Coinsurance	\$20
What isn't covered	
Limits or exclusions	\$4,000
The total Joe would pay is	\$4,420

Mia's Simple Fracture

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

■ The plan's overall deductible	\$750
■ Specialist copayment	\$40
■ Hospital (facility) copayment/coinsurance	\$250/20%
■ Other copayment/coinsurance	\$150/30%

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
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$750
Copayments	\$200
Coinsurance	\$300
What isn't covered	
Limits or exclusions	\$10
The total Mia would pay is	\$1,360

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

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

Discrimination is Against the Law

Language Assistance Services, Auxiliary Aids 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 (consistent with the scope of sex discrimination described in 45 CFR § 92.101(a)(2)). We do not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Blue Cross and Blue Shield of Alabama:

- Provides reasonable modifications and free appropriate auxiliary 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 assistance services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance 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>.

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

English: ATTENTION: Free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-855-216-3144 (TTY: 711) or call Customer Service.

Arabic: انتباه: إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر أيضًا المساعدات والخدمات الإضافية المناسبة لتوفير المعلومات بتنسيقات يسهل الوصول إليها مجانًا. اتصل بالرقم 1-855-216-3144 (الهاتف النصي: 711) أو الاتصال بخدمة العملاء.

Chinese: 请注意: 如果您说普通话, 我们可免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务, 以易读格式向您提供信息。请拨打 1-855-216-3144 (TTY 用户请拨 711) 或致电客户服务部。

French: À NOTER : Si vous parlez français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et des services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1 855 216 3144 (TTY : 711) ou contactez le service client.

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistentenzdienste zur Verfügung. Geeignete Hilfsmittel und Dienstleistungen zur Bereitstellung von Informationen in zugänglichen Formaten sind ebenfalls kostenlos erhältlich. Rufen Sie +1 855 216 3144 (Durchwahl: 711) oder den Kundendienst an.

Gujarati: ધ્યાન આપો: જો તમે ગુજરાતી બોલો છો, તો તમારા માટે નિ:શુલ્ક ભાષા સહાય સેવાઓ ઉપલબ્ધ છે. સુવલ ફોર્મેટમાં માહિતી પ્રદાન કરવા માટેની યોગ્ય સહાય અને સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 1-855-216-3144 (TTY: 711) પર અથવા ગ્રાહક સેવા પર કોલ કરો.

Hindi: ध्यान दें: अगर आप हिन्दी बोलते हैं, तो आपके लिए नि:शुल्क भाषा सहायता सेवाएँ उपलब्ध हैं। आसान प्रारूप में सूचना उपलब्ध कराने के लिए उपयुक्त सहायक साधन और सेवाएँ भी नि:शुल्क उपलब्ध हैं। 1-855-216-3144 (TTY: 711) पर कॉल करें या ग्राहक सेवा को कॉल करें।

Japanese: ご案内: 日本語を話される方には、無料の言語アシスタントサービスをご用意しております。アクセシブルな形式で情報を提供するため、補助器具や支援サービスも無料で提供しております。1-855-216-3144 (TTY: 711) もしくは、カスタマーサービスにお電話でお問合せください。

Korean: 주의: 한국어(를) 하시면 무료 언어 지원 서비스를 이용하실 수 있습니다. 접근 가능한 형식으로 정보를 제공하기 위한 적절한 보조 도구와 서비스도 무료로 제공됩니다. 1-855-216-3144(TTY: 711)로 전화하거나 고객 서비스에 문의하세요.

Lao: ເອົາໃຈໃສ່: ຖ້າເຈົ້າເວົ້າ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາພຣີແມ່ນມີໃຫ້ທ່ານ. ການຊ່ວຍເຫຼືອ ແລະ ການບໍລິການທີ່ເໝາະສົມໃນການສະໜອງຂໍ້ມູນໃນຮູບແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້ແມ່ນຍັງສາມາດໃຊ້ໄດ້ໂດຍບໍ່ເສຍຄ່າ. ໂທ 1-855-216-3144 (TTY: 711) ຫຼື ໂທຫາຝ່າຍບໍລິການລູກຄ້າ.

Portuguese: ATENÇÃO: Se você falar português, serviços gratuitos de assistência linguística estão disponíveis para você. Também estão disponíveis gratuitamente ajudas e serviços auxiliares adequados para fornecer informações em formatos acessíveis. Ligue para 1-855-216-3144 (TTY: 711) ou ligue para o Atendimento ao Cliente.

Russian: ВНИМАНИЕ. Если ваш язык русский язык, к вашим услугам бесплатная языковая помощь. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-855-216-3144 (TTY: 711) или обратитесь в службу поддержки клиентов.

Spanish: ATENCIÓN: Si usted habla español, hay disponibles servicios gratuitos de asistencia lingüística. También hay disponibles, de forma gratuita, ayudas y servicios auxiliares adecuados para dar información en formatos accesibles. Llame al 1-855-216-3144 (TTY: 711) o llame a Servicio al cliente.

Tagalog: ATTENTION: Kung nagsasalita ka ng Tagalog, available sa iyo ang mga libreng serbisyo sa tulong sa wika. Available rin ang naaangkop na mga pantulong na tulong at serbisyo nang walang bayad para magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-855-216-3144 (TTY: 711) o tumawag sa Serbisyo sa Customer.

Turkish: DİKKAT Konuşmanız durumunda Türkçe, ücretsiz dil yardımı hizmetlerinden yararlanabilirsiniz. Erişilebilir formatlarda bilgi sağlamak için uygun yardımcı araçlar ve hizmetler de ücretsiz olarak sunulmaktadır. 1-855-216-3144 (TTY: 711) nolu telefonu veya Müşteri Hizmetlerini arayın.

Vietnamese: CHÚ Ý: Nếu quý vị nói tiếng việt thì dịch vụ hỗ trợ ngôn ngữ miễn phí có sẵn cho quý vị. Chúng tôi cũng có các hỗ trợ và dịch vụ phụ trợ miễn phí phù hợp để cung cấp thông tin ở định dạng dễ tiếp cận. Vui lòng gọi số 1-855-216-3144 (TTY: 711) hoặc gọi Dịch Vụ Khách Hàng.