**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.bcbsal.com or by calling 1-800-292-8868.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | **$200** person **/ $600** family. Does not apply to preventive services, physician, inpatient, coinsurance, non-covered services, most copays, balance-billed charges and pre-certification penalties. | You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**. |
| **Are there other deductibles for specific services?** | Yes. **$250** 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. |
| **Is there an out–of–pocket limit on my expenses?** | Yes. **$600** person. | The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. |
| **What is not included in the out–of–pocket limit?** | Premium, balance-billed charges, health care this plan doesn't cover, copays, most coinsurance, deductibles and pre-certification penalties. | Even though you pay these expenses, they don't count toward the **out-of-pocket limit**. |
| **Is there an overall annual limit on what the plan pays?** | No. | The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits. |
| **Does this plan use a network of providers?** | Yes, this plan uses in-network providers. For a list of in-network providers, see www.bcbsal.com or call 1-800-810-BLUE. | If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**. |
| **Do I need a referral to see a specialist?** | No. You don't need a referral to see a specialist. | You can see the **specialist** you choose without permission from this plan. |
| **Are there services this plan doesn't cover?** | Yes. Precertification is required on all inpatient hospitalizations, some imaging services, home health and hospice. Failure to obtain precertification will result in a penalty or no coverage. | Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**. |

**Questions:** Call 1-800-292-8868 or visit us at www.bcbsal.com.
If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call 1-800-292-8868 to request a copy.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

| Common Medical Event | Services You May Need | Your cost if you use an In Network Provider | Your cost if you use an Out of Network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | 0% coinsurance & $30 copay | 50% coinsurance | Subject to overall deductible for out-of-network |
| | Specialist visit | 0% coinsurance & $30 copay | 50% coinsurance | Subject to overall deductible for out-of-network |
| | Other practitioner office visit | 20% coinsurance for chiropractor | 20% coinsurance for chiropractor | Subject to overall deductible; limited to a $600 maximum payment per member per calendar year; in Alabama, out-of-network not covered |
| | Preventive care/screening/immunization | No Charge | Not Covered | Please see www.bcbsal.com/preventiveservices |
| **If you have a test** | Diagnostic test (x-ray, blood work) | No Charge | 50% coinsurance | Benefits listed are physician services; subject to overall deductible for out-of-network |
| | Imaging (CT/PET scans, MRIs) | No Charge | 50% coinsurance | Benefits listed are physician services; subject to overall deductible for out-of-network |
| **If you need drugs to treat your illness or condition**<br><br>More information about **prescription drug coverage** is available at bcbsal.com/pharmacy. | Generic drugs | 20% coinsurance | Not Covered | Prior authorization required for specific drugs; subject to overall deductible; mental health drugs subject to 50% coinsurance; mail order is available through PrimeMail |
| | Preferred brand drugs | 20% coinsurance | Not Covered | Prior authorization required for specific drugs; subject to overall deductible; mental health drugs subject to 50% coinsurance; mail order is available through PrimeMail |
| | Non-preferred brand drugs | 20% coinsurance | Not Covered | Prior authorization required for specific drugs; subject to overall deductible; mental health drugs subject to 50% coinsurance; mail order is available through PrimeMail |

| Common Medical Event | Services You May Need | Your cost if you use an In Network Provider | Your cost if you use an Out of Network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| | Specialty drugs | 20% coinsurance | Not Covered | Prior authorization required for specific drugs; subject to overall deductible; mental health drugs subject to 50% coinsurance |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 0% coinsurance & $150 copay | 20% coinsurance | Subject to overall deductible for out-of-network; in Alabama, out-of-network not covered |
| | Physician/surgeon fees | No Charge | 50% coinsurance | Subject to overall deductible for out-of-network |
| **If you need immediate medical attention** | Emergency room services | No Charge | 0% coinsurance | Benefits listed are for emergency room services for treatment of accidental injury; other medical emergencies may have higher patient responsibility; subject to overall deductible for out-of-network; physician charges may apply |
| | Emergency medical transportation | 20% coinsurance | 20% coinsurance | Subject to overall deductible |
| | Urgent care | 0% coinsurance & $30 copay | 50% coinsurance | Subject to overall deductible for out-of-network |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 0% coinsurance & $250 per admission | 20% coinsurance & $500 per admission | In Alabama, out-of-network benefits are only available for accidental injury |
| | Physician/surgeon fee | No Charge | 50% coinsurance | Subject to overall deductible for out-of-network |

| Common Medical Event | Services You May Need | Your cost if you use an In Network Provider | Your cost if you use an Out of Network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you have mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | No Charge | 50% coinsurance | Benefits listed are in-network Expanded Psychiatric Services (EPS); services by non EPS in-network and non PPO physicians subject to 50% coinsurance and overall deductible; non EPS limited to 20 visits per member per calendar year; maximum number of visits are combined for mental health and substance abuse |
| | Mental/Behavioral health inpatient services | No Charge | 20% coinsurance | Benefits listed are in-network Expanded Psychiatric Services (EPS); services by non EPS in-network and non PPO physicians subject to 20% coinsurance and overall deductible; in Alabama, out-of-network coinsurance is 50%; 30 day maximum per 12 months; maximum number of visits are combined for mental and substance abuse |
| | Substance use disorder outpatient services | No Charge | 50% coinsurance | Benefits listed are in-network Expanded Psychiatric Services (EPS); services by non EPS in-network and non PPO physicians subject to 50% coinsurance and overall deductible; non EPS limited to 20 visits per member per calendar year; maximum number of visits are combined for mental health and substance abuse |
| | Substance use disorder inpatient services | No Charge | 20% coinsurance | Benefits listed are in-network Expanded Psychiatric Services (EPS); services by non EPS in-network and non PPO physicians subject to 20% coinsurance and overall deductible; in Alabama, out-of-network coinsurance is 50%; 30 day maximum per 12 months; maximum number of visits are combined for mental and substance abuse |
| **If you are pregnant** | Prenatal and postnatal care | No Charge | 50% coinsurance | Benefits listed are outpatient physician services; subject to overall deductible for out-of-network; physician copay may apply |
| | Delivery and all inpatient services | No Charge | 50% coinsurance | Benefits listed are inpatient physician services; subject to overall deductible for out-of-network |

| Common Medical Event | Services You May Need | Your cost if you use an In Network Provider | Your cost if you use an Out of Network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you need help recovering or have other special health needs** | Home health care | No Charge | 20% coinsurance | Subject to overall deductible for out-of-network; in Alabama, out-of-network not covered |
| | Rehabilitation services | 20% coinsurance | 20% coinsurance | Subject to overall deductible; limited to a combined maximum of 30 visits for occupational, physical and speech therapy per member per calendar year; in Alabama, out-of-network coinsurance is 50% for occupational and physical therapy |
| | Habilitation services | 20% coinsurance | 20% coinsurance | Subject to overall deductible; limited to a combined maximum of 30 visits for occupational, physical and speech therapy per member per calendar year; in Alabama, out-of-network coinsurance is 50% for occupational and physical therapy |
| | Skilled nursing care | Not Covered | Not Covered | ——————none—————— |
| | Durable medical equipment | 20% coinsurance | 20% coinsurance | Subject to overall deductible; in Alabama, out-of-network coinsurance is 50% |
| | Hospice service | No Charge | 20% coinsurance | Subject to overall deductible for out-of-network; in Alabama, out-of-network not covered |
| **If your child needs dental or eye care** | Eye exam | No Charge | Not Covered | Please see www.bcbsal.com/preventiveservices |
| | Glasses | Not Covered | Not Covered | ——————none—————— |
| | Dental check-up | No Charge | Not Covered | Please see www.bcbsal.com/preventiveservices |

## Excluded Services & Other Covered Services:

**Services Your Plan Does NOT Cover** (This isn't a complete list. Check your policy or plan document for 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** (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric Surgery (only morbid obesity in limited circumstances)
- Chiropractic care
- Infertility treatment (Assistive Reproductive Technology not covered)
- Non-emergency care when traveling outside the U.S.

## Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.
For more information on your rights to continue coverage, contact the plan administrator at the phone number listed in your benefit booklet. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

## Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact the plan administrator at the phone number listed in your benefit booklet. You may also contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

## Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

## Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

SPANISH (Español): Para obtener asistencia en Español, llame al 1-800-292-8868.

*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*

# About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

## Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $7,090
- **Patient pays** $450

**Sample care costs:**

| | |
|---|---|
| Hospital charges (mother) | $2,700 |
| Routine obstetric care | $2,100 |
| Hospital charges (baby) | $900 |
| Anesthesia | $900 |
| Laboratory tests | $500 |
| Prescriptions | $200 |
| Radiology | $200 |
| Vaccines, other preventive | $40 |
| **Total** | **$7,540** |

**Patient pays:**

| | |
|---|---|
| Deductibles | $20 |
| Copays | $280 |
| Coinsurance | $0 |
| Limits or exclusions | $150 |
| **Total** | **$450** |

Note: These numbers assume the patient has given notice of her pregnancy to the plan. If you are pregnant and have not given notice of your pregnancy, your costs may be higher. For more information, please contact: www.bcbsal.com.

## Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,140
- **Patient pays** $1,350

**Sample care costs:**

| | |
|---|---|
| Prescriptions | $2,900 |
| Medical Equipment and Supplies | $1,300 |
| Office Visits and Procedures | $700 |
| Education | $300 |
| Laboratory tests | $100 |
| Vaccines, other preventive | $100 |
| **Total** | **$5,400** |

**Patient pays:**

| | |
|---|---|
| Deductibles | $200 |
| Copays | $180 |
| Coinsurance | $600 |
| Limits or exclusions | $370 |
| **Total** | **$1,350** |

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: www.bcbsal.com.

# Questions and answers about the Coverage Examples:

## What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

## What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

## Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

## Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

## Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

## Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.