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 1-800-292-8868 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.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>$500 individual/$1,500 family.</td>
<td>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.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes. Preventive services in-network are covered before you meet your deductible.</td>
<td>This plan covers some items and services even if you haven’t yet met the deductible amount. But a copayment or coinsurance may apply.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>Yes. $100 per admission. $200 per admission for out-of-network. There are no other specific deductibles.</td>
<td>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.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>$400 individual.</td>
<td>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.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums, balance-billed charges, health care this plan doesn’t cover, copays, cost sharing for most out-of-network benefits, deductibles and pre-certification penalties.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes. See AlabamaBlue.com or call 1-800-810-BLUE for a list of network providers.</td>
<td>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.</td>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>No.</td>
<td>You can see the specialist you choose without a referral.</td>
</tr>
</tbody>
</table>
All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
</table>
| If you visit a health care provider’s office or clinic | Primary care visit to treat an injury or illness | Network Provider (You will pay the least)  
$40 **copay**/visit  
No overall deductible | Out-of-Network Provider (You will pay the most)  
20% **coinsurance** | In Alabama, out-of-network coinsurance is 50% |
|  | Specialist visit | $40 **copay**/visit  
No overall deductible | 20% **coinsurance** |  |
|  | Preventive care/screening/ immunization | $40 **copay**/visit  
No overall deductible | Not Covered | Age and visit limitations apply; facility charges may apply; 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) | No Charge  
No overall deductible | 20% **coinsurance** | Benefits listed are physician services; in Alabama, out-of-network coinsurance is 50%; facility benefits are also available; precertification may be required |
|  | Imaging (CT/PET scans, MRIs) | No Charge  
No overall deductible | 20% **coinsurance** |  |
| If you need drugs to treat your illness or condition | Tier 1 Drugs | 20% **coinsurance** (retail)  
Not Covered |  |
|  | Tier 2 Drugs | 20% **coinsurance** (retail)  
Not Covered |  |
|  | Tier 3 Drugs | 20% **coinsurance** (retail)  
Not Covered |  |
| More information about prescription drug coverage is available at [AlabamaBlue.com/pharmacy](AlabamaBlue.com/pharmacy) | Facility fee (e.g., ambulatory surgery center) | $125 **copay**  
No overall deductible | 20% **coinsurance** | In Alabama, out-of-network not covered |
|  | Physician/surgeon fees | 0% **coinsurance**  
20% **coinsurance** |  |
| If you have outpatient surgery | Emergency room care | Accident: No Charge  
No overall deductible  
Medical Emergency: $125 **copay**/visit  
No overall deductible | Accident: No Charge  
No overall deductible  
Medical Emergency: $125 **copay**/visit  
No overall deductible | Physician charges will apply |
|  | Emergency medical transportation | 20% **coinsurance**  
20% **coinsurance** |  |
|  | Urgent care | $40 **copay**/visit  
No overall deductible | 20% **coinsurance** | In Alabama, out-of-network coinsurance is 50% |

* For more information about limitations and exceptions, see the plan or policy document at [AlabamaBlue.com](AlabamaBlue.com).
<table>
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<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
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<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
</table>
| If you have a hospital stay                              | Facility fee (e.g., hospital room)   | Network Provider (You will pay the least) $100 per admission deductible & $20 copay/day days 2-11 No overall deductible | Out-of-Network Provider (You will pay the most) $200 per admission deductible & 20% coinsurance No overall deductible  
In Alabama, out-of-network benefits are only available for accidental injury and medical emergency; precertification is required                                                                                                                                |
|                                                           | Physician/surgeon fees               | 0% coinsurance                                                                    | 20% coinsurance  
In Alabama, out-of-network coinsurance is 50%                                                                                                                                                                                                                           |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                  | No Charge EPS $40 copay/visit No overall deductible                                | 20% coinsurance  
Benefits listed are physician services; additional benefits are available; may require higher patient responsibility; in Alabama, out-of-network coinsurance is 50%; precertification is required for intensive outpatient, partial hospitalization and inpatient hospitalization                                                                                                                                |
|                                                           | Inpatient services                   | No Charge EPS No Charge No overall deductible                                      | 20% coinsurance No overall deductible  
In Alabama, out-of-network coinsurance is 50%                                                                                                                                                                                                                                                                 |
| If you are pregnant                                      | Office visits                        | 0% coinsurance                                                                    | 20% 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); in Alabama, out-of-network coinsurance is 50%; for professional services may be required |
|                                                           | Childbirth/delivery professional services | 0% coinsurance                                                                  | 20% coinsurance  
In Alabama, out-of-network not covered; benefits are also available for home infusion services; precertification may be required                                                                                                                                                           |
|                                                           | Childbirth/delivery facility services | $100 per admission deductible & $20 copay/day days 2-11 No overall deductible     | $200 per admission deductible & 20% coinsurance No overall deductible  
In Alabama, out-of-network not covered; benefits are also available for home infusion services; precertification may be required                                                                                                                                                           |
| If you need help recovering or have other special health needs | Home health care                     | No Charge No overall deductible                                                   | 20% coinsurance  
Benefits listed are for Rehabilitation & Habilitation services; each service has a combined maximum of 30 visits for occupational, physical and speech therapy per year; in Alabama, out-of-network coinsurance is 50%; children ages 0-18 with an autistic diagnosis are allowed unlimited visits for occupational, physical and speech therapy |
|                                                           | Rehabilitation services              | 20% coinsurance                                                                  | 20% coinsurance  
In Alabama, out-of-network not covered; benefits are also available for home infusion services; precertification may be required                                                                                                                                                           |
|                                                           | Habilitation services                | 20% coinsurance                                                                  | 20% coinsurance  
In Alabama, out-of-network not covered; benefits are also available for home infusion services; precertification may be required                                                                                                                                                           |
|                                                           | Skilled nursing care                 | Not Covered                                                                       | Not Covered  
In Alabama, out-of-network coinsurance is 50%                                                                                                                                                                                                                                                                 |
|                                                           | Durable medical equipment            | 20% coinsurance                                                                  | 20% coinsurance  
In Alabama, out-of-network not covered; benefits are also available for home infusion services; precertification may be required                                                                                                                                                           |
|                                                           | Hospice services                     | No Charge No overall deductible                                                   | 20% coinsurance  
In Alabama, out-of-network not covered; precertification may be required                                                                                                                                                                                                                                                                 |
| If your child needs dental or eye care                   | Children’s eye exam                  | Not Covered                                                                       | Not Covered  
Not covered; member pays 100%                                                                                                                                                                                                                                                                                              |
|                                                           | Children’s glasses                   | Not Covered                                                                       | Not Covered  
Not covered; member pays 100%                                                                                                                                                                                                                                                                                              |
|                                                           | Children’s dental check-up           | Not Covered                                                                       | Not Covered  
Not covered; member pays 100%                                                                                                                                                                                                                                                                                              |

* For more information about limitations and exceptions, see the plan or policy document at AlabamaBlue.com.
**Excluded Services & Other Covered Services:**

<table>
<thead>
<tr>
<th>Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Acupuncture</td>
</tr>
<tr>
<td>• Cosmetic surgery</td>
</tr>
<tr>
<td>• Dental care (Adult)</td>
</tr>
<tr>
<td>• Dental check-up, child</td>
</tr>
<tr>
<td>• Eye exam, child</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your plan document.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Bariatric surgery (only for morbid obesity in limited circumstances)</td>
</tr>
<tr>
<td>• Chiropractic care</td>
</tr>
</tbody>
</table>

**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: 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 www.dol.gov/ebsa/healthreform or your state insurance department.

**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.

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* For more information about limitations and exceptions, see the plan or policy document at AlabamaBlue.com.
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.

<table>
<thead>
<tr>
<th>Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)</th>
<th>Managing Joe’s type 2 Diabetes (a year of routine in-network care of a well-controlled condition)</th>
<th>Mia’s Simple Fracture (in-network emergency room visit and follow up care)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The plan’s overall deductible</td>
<td>$500</td>
<td>The plan’s overall deductible</td>
</tr>
<tr>
<td>Specialist copay/coinsurance</td>
<td>$40/0%</td>
<td>Specialist copay/coinsurance</td>
</tr>
<tr>
<td>Hospital (facility) copay/coinsurance</td>
<td>$20/0%</td>
<td>Hospital (facility) copay/coinsurance</td>
</tr>
<tr>
<td>Other copay/coinsurance</td>
<td>$40/20%</td>
<td>Other copay/coinsurance</td>
</tr>
</tbody>
</table>

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* | $500 | Copayments | $120 | Coinsurance | $0 |
| --- | --- | --- | --- | --- | --- |
| What isn’t covered | Limits or exclusions | $60 |

The total Peg would pay is: $680

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* | $500 | Copayments | $240 | Coinsurance | $430 |
| --- | --- | --- | --- | --- | --- |
| What isn’t covered | Limits or exclusions | $40 |

The total Joe would pay is: $1,210

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* | $500 | Copayments | $80 | Coinsurance | $210 |
| --- | --- | --- | --- | --- | --- |
| What isn’t covered | Limits or exclusions | $0 |

The total Mia would pay is: $790

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.

*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.