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?	**$350** person **/ $1050** family. Does not apply to preventive services, inpatient, noncovered services, most copays, physician outpatient, 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. **$300** person Per Admission. **$600** person per admission inpatient deductible 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. **$400** 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, out of network coinsurance, most coinsurance, deductibles, pre-certification penalties and pharmacy copays.	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 referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.

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.

Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 7. See your policy or plan document for additional information about **excluded services**.

- **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 & $35 copay	20% coinsurance	Subject to overall deductible for out of network; in Alabama, out of network services covered at 50%
	Specialist visit	0% coinsurance & $35 copay	20% coinsurance	Subject to overall deductible for out of network; in Alabama, out of network services covered at 50%
	Other practitioner office visit	20% coinsurance for chiropractor	20% coinsurance for chiropractor	Subject to overall deductible ; in Alabama, out of network services covered at 50%; limited to $1,000 maximum per person per calendar year
	Preventive care/screening/immunization	0% coinsurance & $35 copay	Not Covered	Facility copay may apply; age and visit limitations will apply
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	20% coinsurance	Subject to overall deductible for out of network; in Alabama, out of network services covered at 50%

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
	Imaging (CT/PET scans, MRIs)	No Charge	20% coinsurance	Subject to overall deductible for out of network; in Alabama, out of network services covered at 50%; precertification may be required for coverage
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at bcbsal.com/pharmacy.	Generic drugs	No Charge	Not Covered	Prior authorization for specific drugs required for coverage
	Preferred brand drugs	20% coinsurance	Not Covered	Prior authorization for specific drugs required for coverage; subject to overall deductible
	Non-preferred brand drugs	20% coinsurance	Not Covered	Prior authorization for specific drugs required for coverage; subject to overall deductible
	Specialty drugs	20% coinsurance	Not Covered	Prior authorization for specific drugs required for coverage; subject to overall deductible
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance & $200 copay	20% coinsurance	Subject to overall deductible for out of network; in Alabama, out of network not covered
	Physician/surgeon fees	0% coinsurance	20% coinsurance	Subject to overall deductible; in Alabama, out of network services covered at 50%
If you need immediate medical attention	Emergency room services	No Charge	No Charge	Subject to overall deductible for out of network; benefits listed are emergency room services for treatment of accidental injury; $35 copay may apply; other medical emergencies may have higher copay
	Emergency medical transportation	20% coinsurance	20% coinsurance	Subject to overall deductible
	Urgent care	0% coinsurance & $35 copay	20% coinsurance	Subject to overall deductible for out of network; in Alabama, out of network services covered at 50%

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 a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance & $50 copay days 2-6 & $300 per admission	20% coinsurance	Copay per day for days 2-6; subject to per admission deductible; in Alabama, out of network not covered; precertification is required for coverage
	Physician/surgeon fee	0% coinsurance	20% coinsurance	Subject to overall deductible; in Alabama, out of network services covered at 50%

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	20% coinsurance	Benefits listed are in network Expanded Psychiatric Services (EPS); subject to overall deductible for out of network; services by non EPS in network providers will have primary care or specialist copay
	Mental/Behavioral health inpatient services	No Charge	20% coinsurance	Benefits listed are in network Expanded Psychiatric Services (EPS); subject to per admission deductible for out of network; in Alabama, out of network not covered; services by in network facilities other than EPS will be subject to copays; precertification is required for coverage
	Substance use disorder outpatient services	No Charge	20% coinsurance	Benefits listed are in network Expanded Psychiatric Services (EPS); subject to overall deductible for out of network; services by non EPS in network providers will have primary care or specialist copay
	Substance use disorder inpatient services	No Charge	20% coinsurance	Benefits listed are in network Expanded Psychiatric Services (EPS); subject to per admission deductible for out of network; in Alabama, out of network not covered; services by in network facilities other than EPS will be subject to copays; precertification is required for coverage
If you are pregnant	Prenatal and postnatal care	0% coinsurance	20% coinsurance	Subject to overall deductible ; inital office visit will have $35 copay for in network services; in Alabama, out of network services covered at 50%

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
	Delivery and all inpatient services	0% coinsurance	20% coinsurance	Subject to overall deductible ; in Alabama, out of network services covered at 50%
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; precertification may be required for coverage; in Alabama, out of network not covered
	Rehabilitation services	20% coinsurance	20% coinsurance	Subject to overall deductible; in Alabama, out of network services covered at 50% for occupational and physical therapy; limited to combined maximum of 30 visits for occupational, physical and speech therapy per calendar year
	Habilitation services	20% coinsurance	20% coinsurance	Subject to overall deductible; in Alabama, out of network services covered at 50% for occupational and physical therapy; limited to combined maximum of 30 visits for occupational, physical and speech therapy per calendar year
	Skilled nursing care	Not Covered	Not Covered	————————none————————
	Durable medical equipment	20% coinsurance	20% coinsurance	Subject to overall deductible; in Alabama, out of network services covered at 50%
	Hospice service	No Charge	20% coinsurance	Subject to overall deductible for out of network; precertification may be required for coverage; in Alabama, out of network not covered
If your child needs dental or eye care	Eye exam	No Charge	No Charge	Limited to $250 maximum per person every two calendar years; benefit limits start new each even year

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
	Glasses	No Charge	No Charge	Limited to $250 maximum per person every two calendar years; benefit limits start new each even year
	Dental check-up	Not Covered	Not Covered	——————none——————

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)
- Dental check-up, child
- Hearing aids
- Long-term care
- Private-duty nursing
- 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.
- Routine eye care (Adult) (limitations apply)

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 Blue Cross and Blue Shield of Alabama at 1-800-292-8868 or the Alabama Department of Insurance at 334-241-4141 or www.aldoi.gov.

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** $6,700
- **Patient pays** $840

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	$350
Copays	$340
Coinsurance	$0
Limits or exclusions	$150
Total	**$840**

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** $4,270
- **Patient pays** $1,130

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	$350
Copays	$210
Coinsurance	$200
Limits or exclusions	$370
Total	**$1,130**

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.

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