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 mylowesbenefits.com or by calling 1-888-474-6365.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$1250** person **/ $3750** family in-network. **$1250** person **/ $3750** family out-of-network. Does not apply to preventive services, drugs, non-covered services, 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?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. For in-network **$6550** person **/ $13100** family. For out-of-network **$6550** person **/ $13100** family.	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 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 AlabamaBlue.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.	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.

Questions: Call 1-888-926-2404 or visit mylowesbenefits.com for medical coverage; Call 1-855-381-1661 or visit Caremark at www.caremark.com for pharmacy coverage.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call 1-888-474-6365 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 & $40 copay	0% coinsurance & $40 copay	——————none——————
	Specialist visit	0% coinsurance & $60 copay	0% coinsurance & $60 copay	——————none——————
	Other practitioner office visit	40% coinsurance for chiropractor	40% coinsurance for chiropractor	Subject to overall deductible; limited to a $500 maximum payment per member per calendar year
	Preventive care/screening/immunization	No Charge	No Charge	Please see AlabamaBlue.com/preventiveservices; additional services may be available
If you have a test	Diagnostic test (x-ray, blood work)	40% coinsurance	40% coinsurance	Benefits listed are physician services; subject to overall deductible; services rendered in a physician's office covered 100% subject to applicable office visit copay; facility benefits are also available
	Imaging (CT/PET scans, MRIs)	40% coinsurance	40% coinsurance	Benefits listed are physician services; subject to overall deductible; precertification is required for coverage; facility benefits are also available

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 drugs to treat your illness or condition More information about prescription drug coverage is available at caremark.com.	Tier 1 - Your Lowest-Cost Option	Retail: $10 Copay Mail Order: $20 Copay	Retail: N/A Mail Order: N/A	3-30 day refills for maintenance drugs at retail
	Tier 2 - Your Midrange-Cost Option	Retail: 35% Coinsurance Mail Order: 35% Coinsurance	Retail: N/A Mail Order: N/A	3-30 day refills for maintenance drugs at retail. Minimum $35 and maximum $70 for retail. Minimum $70 and maximum $140 for mail order.
	Tier 3 - Your Highest-Cost Option	Retail: 35% Coinsurance Mail Order: 35% Coinsurance	Retail: N/A Mail Order: N/A	3-30 day refills for maintenance drugs at retail. Minimum $90 and maximum $170 for retail. Minimum $170 and maximum $340 for mail order.
	Tier 4 - Additional High-Cost Option	Retail: $75 Copay Mail Order: $75 Copay	Retail: N/A Mail Order: N/A	None
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% coinsurance	40% coinsurance	Subject to overall deductible; precertification is required for coverage
	Physician/surgeon fees	40% coinsurance	40% coinsurance	Subject to overall deductible; subject to applicable copay if services are performed in an in-network physician's office; precertification is required for coverage of outpatient surgery
If you need immediate medical attention	Emergency room services	40% coinsurance & $250 copay	40% coinsurance & $250 copay	Deductible does not apply. Copay waived if admitted to the hospital; Non-medical emergency not covered
	Emergency medical transportation	40% coinsurance	40% coinsurance	Subject to in-network deductible; For non-emergency ambulance, $250 copay then 40% coinsurance
	Urgent care	0% coinsurance & $60 copay	0% coinsurance & $60 copay	Benefits listed are for services rendered in an urgent care facility

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)	40% coinsurance	40% coinsurance	Subject to overall deductible; in Alabama, out-of-network benefits are only available for accidental injury; precertification is required for coverage
	Physician/surgeon fee	40% coinsurance	40% coinsurance	Subject to overall deductible; services rendered in a physician's office covered at 100% subject to applicable office visit copay
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	0% coinsurance & $40 copay	0% coinsurance & $40 copay	Benefits listed are outpatient physician services and are available through the Blue Choice Behavioral Health Network or PPO physician; additional benefits are also available with higher patient responsibility; some services require precertification
	Mental/Behavioral health inpatient services	40% coinsurance	40% coinsurance	Benefits listed are inpatient physician services and are available through the Blue Choice Behavioral Health Network or PPO physician; subject to overall deductible; additional benefits are also available; precertification is required
	Substance use disorder outpatient services	0% coinsurance & $40 copay	0% coinsurance & $40 copay	Benefits listed are outpatient physician services and are available through the Blue Choice Behavioral Health Network or PPO physician; additional benefits are also available with higher patient responsibility; some services require precertification
	Substance use disorder inpatient services	40% coinsurance	40% coinsurance	Benefits listed are inpatient physician services and are available through the Blue Choice Behavioral Health Network or PPO physician; subject to overall deductible; additional benefits are also available; precertification is required
If you are pregnant	Prenatal and postnatal care	40% coinsurance	40% coinsurance	Benefits listed are outpatient physician services; subject to overall deductible

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	40% coinsurance	40% coinsurance	Benefits listed are inpatient physician services; subject to overall deductible
If you need help recovering or have other special health needs	Home health care	0% coinsurance	0% coinsurance	Subject to overall deductible; limited to a maximum of 120 visits per member per calendar year; precertification is required for coverage
	Rehabilitation services	40% coinsurance	40% coinsurance	Subject to overall deductible; limited to a combined maximum of 60 visits for rehabilitative occupational, physical and speech therapy per member per calendar year; clinical review after the first visit; precertification is required for coverage
	Habilitation services	40% coinsurance	40% coinsurance	Subject to overall deductible; limited to a combined maximum of 60 visits for habilitative occupational, physical and speech therapy per member per calendar year; clinical review after the first visit; precertification is required for coverage
	Skilled nursing care	40% coinsurance	40% coinsurance	Subject to overall deductible; limited to a maximum of 120 days per member per calendar year; precertification is required for coverage
	Durable medical equipment	40% coinsurance	40% coinsurance	Subject to overall deductible; precertification is required for rentals and purchases over $500
	Hospice service	0% coinsurance	0% coinsurance	Subject to the overall deductible; services subject to 40% coinsurance after the first $10,000; precertification is required for coverage
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	——————none——————
	Glasses	Not Covered	Not Covered	——————none——————
	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
- Eye exam, child
- Glasses, child
- Long-term care
- Routine eye care (Adult)
- 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 (1 per lifetime)
- Chiropractic care ($500 per calendar year)
- Hearing aids (1 hearing aid per ear, per every 36 months)
- Infertility treatment (limited to diagnosis and treatment of medical condition)
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing (limited to 70 visits per calendar year)
- Routine foot care (limitations may 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 the plan administrator at 1-888-474-6365. 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 healthcare 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% health coverage. This plan does meet the minimum value standard for the benefits it provides.

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** $3,680
- **Patient pays** $3,860

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	$1250
Copays	$60
Coinsurance	$2400
Limits or exclusions	$150
Total	$3,860

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: AlabamaBlue.com..

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,950
- **Patient pays** $1,450

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	$20
Copays	$1010
Coinsurance	$50
Limits or exclusions	$370
Total	$1,450

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.

Questions: Call 1-888-926-2404 or visit mylowesbenefits.com for medical coverage; Call 1-855-381-1661 or visit Caremark at www.caremark.com for pharmacy coverage.

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

Language Access Services and Notice of Nondiscrimination:

Blue Cross and Blue Shield of Alabama 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 Service, 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 بـ 1-855-216-3144 (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。