BCBS: Lowe's Companies, Inc. Option II

Coverage For: Individual + Family **Plan Type:** PPO

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 1-844-475-6937 or visit us at mylowesbenefits.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 1-888-926-2404 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$1,500 individual/$4,500 family in-network. $3,000 individual/$9,000 family 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/. Refer to *If you are pregnant* below for how completing maternity wellness activities may impact newborn deductibles.
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?	For in-network $6,000 individual/$12,000 family. For out-of-network $13,100 individual/$26,200 family.	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.
What is not included in the out–of–pocket limit?	Premiums, 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.
Will you pay less if you use a network provider?	Yes. See AlabamaBlue.com or call 1-888-926-2404 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 No overall deductible	50% coinsurance	None
	Specialist visit	$60 copay/visit No overall deductible	50% coinsurance	
	Preventive care/screening/ immunization	No Charge No overall deductible	50% coinsurance	Please visit AlabamaBlue.com/preventiveservices; additional services are available. 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)	40% coinsurance	50% coinsurance	Benefits listed are for physician services in an outpatient setting; services rendered at an in-network physician's office covered at 100% of the allowed amount not subject to overall deductible; subject to applicable office visit copay; facility charges may also apply; precertification is required for imaging
	Imaging (CT/PET scans, MRIs)	40% coinsurance	50% coinsurance	Benefits listed are physician services in an outpatient setting; facility charges may also apply; precertification is required for imaging

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 drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com	Generic Drugs	$15 Copay per prescription (retail); $30 Copay per prescription (mail order)	If you use a Non-Network Pharmacy, you are responsible for payment upfront. You may be reimbursed based on the lowest contracted amount, minus any applicable deductible or copayment amount.	Deductible does not apply Out-of-pocket limit applies Covers up to a 30-day supply (retail & specialty); 31-90 day supply (mail order) Once the annual Out-of-pocket is met, you pay nothing for covered prescription medication Fertility medications are administered through Progyny. Please call (833) 283-1968 to register for benefit
	Preferred Brand Drugs	40% Copay with a Minimum of $40 up to a Maximum of $80 per prescription (retail); 40% Copay with a Minimum of $80 up to a Maximum of $160 per prescription (mail order).		
	Non-Preferred Brand Drugs	40% Copay with a Minimum of $100 up to a Maximum of $180 per prescription (retail); 40% Copay with a Minimum of $200 up to a Maximum of $360 per prescription (mail order).		
	Specialty Drugs	$100 Copay per prescription		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% coinsurance	50% coinsurance	In-Alabama, out-of-network not covered; precertification may be required
	Physician/surgeon fees	40% coinsurance	50% coinsurance	Surgery rendered at an in-network physician's office subject to applicable office visit copay; precertification may be required for outpatient surgery
If you need immediate medical attention	Emergency room care	Accident: $250 copay/visit & 40% coinsurance No overall deductible Medical Emergency: $250 copay/visit & 40% coinsurance No overall deductible	Accident: $250 copay/visit & 40% coinsurance No overall deductible Medical Emergency: $250 copay/visit & 40% coinsurance No overall deductible	Physician charges will apply; copay waived if admitted to the hospital; non-medical emergencies not covered.

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

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)	
	Emergency medical transportation	40% coinsurance	40% coinsurance	Subject to in-network overall deductible; non-emergency ambulance services will be subject to higher patient responsibility
	Urgent care	$60 copay/visit No overall deductible	50% coinsurance	Benefits listed are for services rendered in an urgent care facility
If you have a hospital stay	Facility fee (e.g., hospital room)	40% coinsurance	$400 copay/admission & 50% coinsurance	In Alabama, out-of-network benefits are only available for accidental injury; precertification is required
	Physician/surgeon fees	40% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% coinsurance & $40 Copay	50% coinsurance	Benefits listed are outpatient provider services and are available through the Magellan Healthcare Network of providers; subject to overall deductible; additional benefits are also available with higher patient responsibility; some services require precertification
	Inpatient services	40% coinsurance	$400 copay per admission; 50% coinsurance	Benefits listed are inpatient services and are available through the Magellan Healthcare Network of providers; subject to overall deductible; additional benefits are also available; precertification is required
If you are pregnant	Office visits	40% coinsurance	50% 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); initial office visit subject to applicable office visit copay Completion of certain Maternity wellness activities may result in a waived newborn deductible
	Childbirth/delivery professional services	40% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	40% coinsurance	$400 copay/admission & 50% coinsurance	

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

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	0% coinsurance	50% coinsurance	120 visits/year; precertification is required
	Rehabilitation services	40% coinsurance	50% coinsurance	Benefits listed are for Rehabilitative and Habilitative services; limited to a combined maximum of 60 visits for occupational, physical and speech therapy per year; clinical review following 25th visit per discipline; unlimited visits for treatment of mental health disorders (any age) and autism for children (any age); office visits related to autism subject to applicable office visit copay; precertification is required
	Habilitation services	40% coinsurance	50% coinsurance	
	Skilled nursing care	40% coinsurance	50% coinsurance	120 days/year; precertification is required
	Durable medical equipment	40% coinsurance	50% coinsurance	Precertification required for some DME rentals over $1,500 and DME purchases over $1,500 (excluding braces and orthotics); prosthetics require precertification for both DME rentals and purchases over $1,500
	Hospice services	No Charge No overall deductible	50% coinsurance	Precertification is required for inpatient hospice; hospice services rendered in the home do not require precertification
If your child needs dental or eye care	Children's eye exam	No Charge No overall deductible	50% coinsurance	Routine eye and dental coverage is provided for children as required by law
	Children's glasses	Not Covered	Not Covered	
	Children's dental check-up	No Charge No overall deductible	50% coinsurance	

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)
- Long-term care
- Routine eye care (Adult)
- Glasses, child
- Intellectual disability Habilitative services
- Weight loss programs
- Routine foot care
- Private-duty nursing

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery (limited to 1 per lifetime)
- Chiropractic care (clinical review following 25th visit)
- Hearing aids (limited to 1 hearing aid per ear every 3 calendar years)
- Non-emergency care when traveling outside the U.S. (limitations apply)
- Fertility Treatments: Fertility and Assisted Reproductive Technology treatments are administered through Progyny. Please call (833) 283-1968 to register for benefit

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.

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.

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

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$1,500
Specialist copay/coinsurance	$60/0%
Hospital (facility) copay/coinsurance	$0/40%
Other copay/coinsurance	$250/40%

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	$1,500
Copayments	$10
Coinsurance	$4,400
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$5,970

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$1,500
Specialist copay/coinsurance	$60/0%
Hospital (facility) copay/coinsurance	$0/40%
Other copay/coinsurance	$250/40%

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	$300
Copayments	$600
Coinsurance	$300
What isn't covered	
Limits or exclusions	$40
The total Joe would pay is	$1,240

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$1,500
Specialist copay/coinsurance	$60/0%
Hospital (facility) copay/coinsurance	$0/40%
Other copay/coinsurance	$250/40%

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	$1,500
Copayments	$400
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$2,200

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:mylowesbenefits.com.

The plan would be responsible for the other costs of these EXAMPLE covered services.