

BCBS: Lowe's Companies, Inc. Choice Account with Optional HSA

Coverage For: Individual + Family Plan Type: HDHP



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 ?	\$2,000 individual/\$5,000 family coverage in-network. \$4,000 individual/\$10,000 family coverage 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 , the overall family deductible must be met before the plan begins to pay for any individual (even if that individual has satisfied the individual 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/ .
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 ?	\$6,000 individual/\$12,000 family coverage in-network. \$12,000 individual/\$24,000 family coverage out-of-network. Maximum amount that any one person will satisfy towards the annual family out-of-pocket limit is \$6,000.	The individual 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 individual 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, out-of-network deductibles, copayments & coinsurance, the value of manufacturer coupons, 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 medical/surgical network providers or call 1-877-543-3875 for a list of network mental health & substance abuse 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). For certain substance abuse services and hip, knee and spine surgeries, you pay the least if you use a Center of Excellence. You pay more if you use another network provider . 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. For telehealth services, you may pay less by using the Lowe's Teladoc program (a separate program from this plan).
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	50% coinsurance (including telehealth*)	60% coinsurance	For telehealth services, you may pay less by using the Lowe's Teladoc program instead of a virtual visit through a non-Teladoc provider.
	Specialist visit	50% coinsurance (including telehealth*)	60% coinsurance	
	Preventive care/screening/immunization	No Charge; deductible does not apply	60% 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)	50% coinsurance	60% coinsurance	Benefits listed are physician services in an outpatient setting; facility charges may also apply.
	Imaging (CT/PET scans, MRIs)	50% coinsurance	60% 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	50% coinsurance	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 and out-of-pocket limit applies Covers up to a 30-day supply with retail & specialty pharmacies, 31-90 day supply with mail order pharmacies and a 30-day supply for specialty drugs. Once the annual out-of-pocket limit is met, you pay nothing for covered prescription medication Important: The cost of fertility medications may differ and are administered through Progyny. Please call (833) 283-1968 to register for benefits.
	Preferred Brand Drugs	50% coinsurance		
	Non-Preferred Brand Drugs	50% coinsurance		
	Specialty Drugs	50% coinsurance		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	50% coinsurance	60% coinsurance	In Alabama, out-of-network not covered; precertification is required Second opinion via 2 nd .MD may be required or \$1,000 penalty may apply for hip, knee and spine surgeries.
	Physician/surgeon fees	50% coinsurance	60% coinsurance	Precertification may be required for outpatient surgery
If you need immediate medical attention	Emergency room care	Accident or Medical Emergency: 50% coinsurance	Accident or Medical Emergency: 50% coinsurance	Physician charges will apply; non-medical emergencies not covered
	Emergency medical transportation	50% coinsurance	50% coinsurance	Subject to in-network overall deductible ; non-emergency ambulance services will be subject to 60% coinsurance .
	Urgent care	50% coinsurance	60% coinsurance	Benefits listed are for services rendered in an urgent care facility

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 have a hospital stay	Facility fee (e.g., hospital room)	50% coinsurance	60% coinsurance	In Alabama, out-of-network benefits are only available for accidental injury; precertification is required Second opinion via 2 nd .MD may be required or \$1,000 penalty may apply for hip, knee and spine surgeries.
	Physician/surgeon fees	50% coinsurance	60% coinsurance	None
If you need mental health, behavioral health, or substance abuse services For more information about behavioral health services call Magellan Healthcare at 1-877-543-3875	Outpatient services	50% coinsurance	60% coinsurance	These benefits are administered by Magellan. Some outpatient services require precertification.
	Inpatient services	50% coinsurance 0% coinsurance for substance abuse services at a Center of Excellence; 50% coinsurance for substance abuse services at other in-network providers	60% coinsurance	These benefits are administered by Magellan. Substance abuse services are inpatient, detoxification, residential, partial hospitalization and intensive outpatient levels of care; precertification is required The Center of Excellence benefit for substance abuse services is not available without precertification.
If you are pregnant	Office visits	No charge, deductible waived for routine visits; 50% coinsurance	60% 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)
	Childbirth/delivery professional services	50% coinsurance	60% coinsurance	
	Childbirth/delivery facility services	50% coinsurance	60% coinsurance	

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	50% coinsurance	60% coinsurance	120 visits/year; benefits are also available for home infusion services; precertification is required
	Rehabilitation services	50% coinsurance	60% coinsurance	Benefits listed are for Rehabilitative and Habilitative services; unlimited visits, subject to medical necessity following 25th visit per discipline; unlimited visits for treatment of mental health disorders (any age) and autism for children (any age); precertification is required; habilitative services for diagnosis/treatment of intellectual disability not covered.
	Habilitation services	50% coinsurance	60% coinsurance	
	Skilled nursing care	50% coinsurance	60% coinsurance	120 days/year; precertification is required
	Durable medical equipment	50% coinsurance	60% 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	0% coinsurance	60% 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 deductible does not apply	60% 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 deductible does not apply	60% 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 .)		
<ul style="list-style-type: none">• Acupuncture• Cosmetic surgery• Dental care (Adult)	<ul style="list-style-type: none">• Long-term care• Routine eye care (Adult)• Glasses (unless to replace human lens function following surgery, injury or defect)• Habilitative services for diagnosis/treatment of intellectual disability	<ul style="list-style-type: none">• Weight loss programs (other than obesity screening and counseling)• Routine foot care• Private-duty nursing• Surrogacy, unless surrogate is a member of the plan (only surrogate member covered) or non-surrogate parent is a member of the plan (only child covered)

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)	
<ul style="list-style-type: none">• Bariatric surgery (limited to 1 per lifetime)• Chiropractic care (review for medical necessity following 25th visit)• Hearing aids (limited to 1 hearing aid per ear every 2 calendar years)	<ul style="list-style-type: none">• Non-emergency care when traveling outside the U.S. (limitations apply)• Fertility Treatments

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.—————

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)		Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ The plan's overall deductible	\$2,000	■ The plan's overall deductible	\$2,000	■ The plan's overall deductible	\$2,000
■ Specialist copay/coinsurance	\$0/50%	■ Specialist copay/coinsurance	\$0/50%	■ Specialist copay/coinsurance	\$0/50%
■ Hospital (facility) copay/coinsurance	\$0/50%	■ Hospital (facility) copay/coinsurance	\$0/50%	■ Hospital (facility) copay/coinsurance	\$0/50%
■ Other copay/coinsurance	\$0/50%	■ Other copay/coinsurance	\$0/50%	■ Other copay/coinsurance	\$0/50%
This EXAMPLE event includes services like: Specialist office visits (<i>prenatal care</i>) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests (<i>ultrasounds and blood work</i>) Specialist visit (<i>anesthesia</i>)		This EXAMPLE event includes services like: Primary care physician office visits (<i>including disease education</i>) Diagnostic tests (<i>blood work</i>) Prescription drugs Durable medical equipment (<i>glucose meter</i>)		This EXAMPLE event includes services like: Emergency room care (<i>including medical supplies</i>) Diagnostic tests (<i>x-ray</i>) Durable medical equipment (<i>crutches</i>) Rehabilitation services (<i>physical therapy</i>)	
Total Example Cost	\$12,700	Total Example Cost	\$5,600	Total Example Cost	\$2,800
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
<i>Cost Sharing</i>		<i>Cost Sharing</i>		<i>Cost Sharing</i>	
Deductibles	\$2,000	Deductibles	\$2,000	Deductibles	\$2,000
Copayments	\$0	Copayments	\$0	Copayments	\$0
Coinsurance	\$4,000	Coinsurance	\$1,700	Coinsurance	\$400
<i>What isn't covered</i>		<i>What isn't covered</i>		<i>What isn't covered</i>	
Limits or exclusions	\$60	Limits or exclusions	\$40	Limits or exclusions	\$0
The total Peg would pay is	\$6,060	The total Joe would pay is	\$3,740	The total Mia would pay is	\$2,400

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: <http://mylowesbenefits.com/>.

