BCBS: Lowe's Companies, Inc. Option I

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?	$1,000 individual/$3,000 family coverage in-network. $2,000 individual/$6,000 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, 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?	$6,000 individual/$12,000 family coverage in-network $13,100 individual/$26,200 family coverage out-of-network	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, out-of-network deductibles, copayments & coinsurance, the value of prescription drug 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. 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	$20 copay/visit (including telehealth*) deductible does not apply	50% 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 ($20 copay for primary care; $35 copay for dermatologist visit within Teladoc program). The first Teladoc visit is free.
	Specialist visit	$40 copay/visit (including telehealth*) deductible does not apply	50% coinsurance	
	Preventive care/screening/ immunization	No Charge deductible does not apply	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)	30% coinsurance in an inpatient or outpatient facility setting No Charge in a physician's office setting; deductible does not apply (applicable copayment for physician visit applies)	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)	30% coinsurance	50% coinsurance	Benefits listed are physician services in an outpatient setting; facility charges may also apply; precertification is required for imaging

* 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 drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com	Generic Drugs	$10 copay per prescription (retail); $20 copay per prescription (mail order); deductible does not apply	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	Covers up to a 30-day supply with retail & specialty pharmacies; a 31-90 day supply with mail order pharmacies. Once the annual out–of–pocket limit is met, you pay nothing for covered prescription medication **Important:** The cost of fertility medications differ and are administered through Progyny. Please call (833) 283-1968 to register for benefits. **PrudentRx Program for Specialty Drugs:** You will be automatically enrolled in the PrudentRx Program, but can opt out. PrudentRx eligible specialty drugs are covered with $0 cost sharing. If you choose to opt out or fail to enroll in any copay assistance as required by a manufacturer, you are responsible for the 30% coinsurance for PrudentRx eligible drugs. Copays for these medications (made by you/the plan/assistance program) will not count toward your deductible. Because certain specialty medications do not qualify as "essential health benefits" under the ACA, your cost share payments for these medications, whether made by you or a manufacturer copayment assistance program, do not count towards your out–of–pocket limit.
	Preferred Brand Drugs	35% coinsurance with a Minimum of $35 up to a Maximum of $70 per prescription (retail); 35% coinsurance with a Minimum of $70 up to a Maximum of $140 per prescription (mail order); deductible does not apply		
	Non-Preferred Brand Drugs	35% coinsurance with a Minimum of $90 up to a Maximum of $170 per prescription (retail); 35% coinsurance with a Minimum of $180 up to a Maximum of $340 per prescription (mail order); deductible does not apply		
	Specialty Drugs	PrudentRX eligible medicines: 30% after deductible is met; $0 if enrolled in PrudentRX. Non-eligible medicines: $75 copay; deductible does not apply.		

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 outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance 0% coinsurance for hip, knee or spine surgery at a Center of Excellence	50% coinsurance	In Alabama, out-of-network not covered; precertification may be required Second opinion via 2nd.MD may be required or $1,000 penalty may apply for hip, knee and spine surgeries.
	Physician/surgeon fees	30% coinsurance 0% coinsurance for hip, knee or spine surgery at a Center of Excellence	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 or Medical Emergency: $250 copay/visit & 30% coinsurance; deductible does not apply	Accident or Medical Emergency: $250 copay/visit & 30% coinsurance; deductible does not apply	Physician charges will apply; copay waived if admitted to the hospital; non-medical emergency not covered.
	Emergency medical transportation	30% coinsurance	30% coinsurance	Non-emergency ambulance services will be subject to a 30% coinsurance and a $250 copayment per occurrence
	Urgent care	$40 copay/visit deductible does not apply	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)	30% coinsurance 0% coinsurance for hip, knee or spine surgery at a Center of Excellence	$400 copay/admission & 50% coinsurance	In Alabama, out-of-network benefits are only available for accidental injury; precertification is required Second opinion via 2nd.MD may be required or $1,000 penalty may apply for hip, knee and spine surgeries.

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)	
	Physician/surgeon fees	30% coinsurance (inpatient and outpatient facility setting) No charge; deductible does not apply (physician's office setting)	50% 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	$20 copay/visit	50% coinsurance	These benefits are administered by Magellan. Some outpatient services require precertification.
	Inpatient services	30% coinsurance 0% coinsurance for substance abuse services at a Center of Excellence; 30% coinsurance for substance abuse services at other in-network providers	$400 copay/admission & 50% coinsurance	These benefits are administered by Magellan. Substance abuse services are inpatient, detoxification, residential, partial hospitalization and intensive outpatient level 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; 30% 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	30% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	30% coinsurance	$400 copay/admission & 50% 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	0% coinsurance	50% coinsurance	120 visits/year; benefits are also available for home infusion services; precertification is required
	Rehabilitation services	30% coinsurance	50% coinsurance	Benefits listed are for Rehabilitative and Habilitative; unlimited visits, subject to medical necessity following 25th visit per discipline; unlimited visits for treatment for 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. Habilitative services for diagnosis/treatment of intellectual disability not covered.
	Habilitation services	30% coinsurance	50% coinsurance	
	Skilled nursing care	30% coinsurance	50% coinsurance	120 days/year; precertification is required
	Durable medical equipment	30% 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; deductible does not apply	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 deductible does not apply	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 deductible does not apply	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, (unless to replace human lens function following surgery, injury or defect)
- Habilitative services for diagnosis/treatment of intellectual disability
- 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.)

- 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)
- 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.

* 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	$1,000
Specialist copay/coinsurance	$40/0%
Hospital (facility) copay/coinsurance	$0/30%
Other copay/coinsurance	$250/35%

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	$1,000
Copayments	$10
Coinsurance	$3,500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$4,570

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

The plan's overall deductible	$1,000
Specialist copay/coinsurance	$40/0%
Hospital (facility) copay/coinsurance	$0/30%
Other copay/coinsurance	$250/35%

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	$500
Coinsurance	$300
What isn't covered	
Limits or exclusions	$40
The total Joe would pay is	$1,140

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

The plan's overall deductible	$1,000
Specialist copay/coinsurance	$40/0%
Hospital (facility) copay/coinsurance	$0/30%
Other copay/coinsurance	$250/35%

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	$1,000
Copayments	$400
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,800

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/.