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 1-800-292-8868 or visit us at AlabamaBlue.com/b2020BlueChoicePlatinum. 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 AlabamaBlue.com/SBCGlossary or call 1-800-292-8868 to request a copy.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>$100 individual / $200 family in-network. $100 individual / $200 family out-of-network.</td>
<td>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.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes. In-network preventive services, outpatient hospital services, inpatient hospital services, most physician services, some pediatric dental services, drugs, non-covered services and balance-billed charges are covered before you meet your deductible.</td>
<td>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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>Yes. $300 per admission for out-of-network hospital stay. There are no other specific deductibles.</td>
<td>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.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>For in-network $4,000 individual / $8,000 family.</td>
<td>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.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>All out-of-network cost sharing amounts (deductibles, copays and coinsurance), except out-of-network mental health disorders &amp; substance abuse medical emergency services, premiums, balance-billed charges and healthcare this plan doesn’t cover.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes. See AlabamaBlue.com or call 1-800-810-BLUE for a list of network providers.</td>
<td>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. 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.</td>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>No.</td>
<td>You can see the specialist you choose without a referral.</td>
</tr>
</tbody>
</table>
All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Network Provider (You will pay the least)</th>
<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you visit a health care provider’s office or clinic</strong></td>
<td>Primary care visit to treat an injury or illness</td>
<td>$20 <strong>copay</strong>/visit  No overall deductible</td>
<td>20% <strong>coinsurance</strong></td>
<td>In Alabama, out-of-network coinsurance is 50%</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$30 <strong>copay</strong>/visit  No overall deductible</td>
<td>20% <strong>coinsurance</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/ immunization</td>
<td>No Charge  No overall deductible</td>
<td>Not Covered</td>
<td>Please visit AlabamaBlue.com/PreventiveServices and AlabamaBlue.com/StandardACAPreventiveDrugList. You may have to pay for services that aren’t preventive. Ask your provider if the services you need are preventive, then check your plan benefits for coverage. For a printed copy, please contact Customer Service at 1-800-292-8868.</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>No Charge  No overall deductible</td>
<td>20% <strong>coinsurance</strong></td>
<td>Benefits listed are physician services; in Alabama, out-of-network coinsurance is 50%; in Alabama, out-of-network facilities not covered; some diagnostic tests and imaging may require precertification; if no precertification is obtained, no benefits are available</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>No Charge  No overall deductible</td>
<td>20% <strong>coinsurance</strong></td>
<td></td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td>Tier 1 Drugs</td>
<td>$10 <strong>copay</strong> (retail)  $25 <strong>copay</strong> (mail order)  No overall deductible</td>
<td>Not Covered</td>
<td>Benefits listed are only available through the ValueONE Network; precertification is required for some drugs; if precertification is not obtained, no coverage</td>
</tr>
<tr>
<td></td>
<td>Tier 2 Drugs</td>
<td>$20 <strong>copay</strong> (retail)  $50 <strong>copay</strong> (mail order)  No overall deductible</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tier 3 Drugs</td>
<td>$35 <strong>copay</strong> (retail)  $87.50 <strong>copay</strong> (mail order)  No overall deductible</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tier 4 Drugs</td>
<td>$75 <strong>copay</strong> (retail)  $187.50 <strong>copay</strong> (mail order)  No overall deductible</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tier 5 Drugs (Preferred Specialty)</td>
<td>$100 <strong>copay</strong> (retail)  No overall deductible</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tier 6 Drugs (Non-Preferred Specialty)</td>
<td>$200 <strong>copay</strong> (retail)  No overall deductible</td>
<td>Not Covered</td>
<td></td>
</tr>
</tbody>
</table>

* More information about **prescription drug coverage** is available at AlabamaBlue.com/2020SourcePlusRx2DrugList.

* For more information about limitations and exceptions, see the plan or policy document at AlabamaBlue.com/b2020BlueChoicePlatinum.
## Common Medical Event Services You May Need

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you have outpatient surgery</strong></td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>$150 <strong>copay</strong>/visit No overall deductible</td>
<td>In Alabama, out-of-network not covered; precertification may be required</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No Charge No overall deductible</td>
<td>In Alabama, out-of-network coinsurance is 50%</td>
</tr>
<tr>
<td><strong>If you need immediate medical attention</strong></td>
<td>Emergency room care</td>
<td>Accident: $150 <strong>copay</strong>/visit Medical Emergency: $150 <strong>copay</strong>/visit</td>
<td>Physician charges will apply</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>20% <strong>coinsurance</strong></td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$20 <strong>copay</strong>/visit No overall deductible</td>
<td>In Alabama, out-of-network coinsurance is 50%</td>
</tr>
<tr>
<td><strong>If you have a hospital stay</strong></td>
<td>Facility fee (e.g., hospital room)</td>
<td>$150 <strong>copay</strong>/day for days 1-5 No overall deductible</td>
<td>In Alabama, out-of-network benefits are only available for accidental injury and medical emergency; precertification is required; if no precertification is obtained, no benefits are available</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No Charge No overall deductible</td>
<td>In Alabama, out-of-network coinsurance is 50%; precertification is required; if no precertification is obtained, no benefits are available</td>
</tr>
<tr>
<td><strong>If you need mental health, behavioral health, or substance abuse services</strong></td>
<td>Outpatient services</td>
<td>$30 <strong>copay</strong>/visit No overall deductible</td>
<td>Benefits listed are physician services; additional benefits are available; precertification is required for intensive outpatient, partial hospitalization and inpatient hospitalization; in Alabama, out-of-network coinsurance is 50%</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>No Charge No overall deductible</td>
<td>20% <strong>coinsurance</strong></td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see the plan or policy document at AlabamaBlue.com/b2020BlueChoicePlatinum.
### If you are pregnant

<table>
<thead>
<tr>
<th>Service</th>
<th>Cost Sharing</th>
<th>Maternity Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office visits</td>
<td>No Charge No overall deductible</td>
<td>No Charge No overall deductible</td>
</tr>
<tr>
<td>Childbirth/delivery professional services</td>
<td>No Charge No overall deductible</td>
<td>No Charge No overall deductible</td>
</tr>
<tr>
<td>Childbirth/delivery facility services</td>
<td>$150 copay/day for days 1-5 No overall deductible</td>
<td>$300 per admission deductible &amp; 20% coinsurance No overall deductible</td>
</tr>
</tbody>
</table>

Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound); in Alabama, out-of-network coinsurance is 50% for professional services.

### If you need help recovering or have other special health needs

<table>
<thead>
<tr>
<th>Service</th>
<th>Cost Sharing</th>
<th>Maternity Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home health care</td>
<td>No Charge No overall deductible</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>Rehabilitation services</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>Habilitation services</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td>Not Covered Not Covered</td>
<td>Not Covered Not Covered</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>Hospice services</td>
<td>No Charge No overall deductible</td>
<td>20% coinsurance</td>
</tr>
</tbody>
</table>

In Alabama, out-of-network not covered; precertification is required outside of Alabama; if no precertification is obtained, no benefits are available.

### If your child needs dental or eye care

<table>
<thead>
<tr>
<th>Service</th>
<th>Cost Sharing</th>
<th>Maternity Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children’s eye exam</td>
<td>20% coinsurance</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Children’s glasses</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>Children’s dental check-up</td>
<td>No Charge No overall deductible</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

Benefits include diagnostic and preventive services for members up to the end of the month in which the member turns 19; additional benefits available; limitations apply.

---

* For more information about limitations and exceptions, see the plan or policy document at AlabamaBlue.com/b2020BlueChoicePlatinum.
### 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.)

- Abortion (except in cases of rape, incest, or when life of the mother is endangered)
- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Long-term care
- Private-duty nursing
- Routine foot care
- Skilled nursing care
- Weight loss programs
- Hearing aids
- Long-term care
- Private-duty nursing
- Routine foot care
- Skilled nursing care
- Weight loss programs

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

- Bariatric surgery (only morbid obesity in limited circumstances; physician benefits available in-network only and subject to 20% coinsurance)
- Chiropractic care (limited to 15 visits per member per calendar year)
- Infertility treatment (Assisted Reproductive Technology not covered)
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult) (adults age 19 and older, limited to $75 maximum per member for one exam and refraction per calendar year for in-network providers)
- Routine foot care
- Skilled nursing care
- Weight loss programs
- Hearing aids
- Long-term care
- Private-duty nursing
- Routine foot care
- Skilled nursing care
- Weight loss programs

### 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](http://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](http://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 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](http://www.dol.gov/ebsa/healthreform) or your state insurance department.

### Does this plan provide Minimum Essential Coverage? Yes

If you don’t have Minimum Essential Coverage for a month, you’ll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

### 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.

* For more information about limitations and exceptions, see the plan or policy document at AlabamaBlue.com/b2020BlueChoicePlatinum.
### 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.

<table>
<thead>
<tr>
<th>Peg is Having a Baby (9 months of in-network prenatal care and a hospital delivery)</th>
<th>Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)</th>
<th>Mia's Simple Fracture (in-network emergency room visit and follow up care)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The plan's overall deductible</strong></td>
<td><strong>The plan's overall deductible</strong></td>
<td><strong>The plan's overall deductible</strong></td>
</tr>
<tr>
<td>$100</td>
<td>$100</td>
<td>$100</td>
</tr>
<tr>
<td><strong>Specialist copay/coinsurance</strong></td>
<td><strong>Specialist copay/coinsurance</strong></td>
<td><strong>Specialist copay/coinsurance</strong></td>
</tr>
<tr>
<td>$30/0%</td>
<td>$30/0%</td>
<td>$30/0%</td>
</tr>
<tr>
<td><strong>Hospital (facility) copay/coinsurance</strong></td>
<td><strong>Hospital (facility) copay/coinsurance</strong></td>
<td><strong>Hospital (facility) copay/coinsurance</strong></td>
</tr>
<tr>
<td>$150/0%</td>
<td>$150/0%</td>
<td>$150/0%</td>
</tr>
<tr>
<td><strong>Other copay/coinsurance</strong></td>
<td><strong>Other copay/coinsurance</strong></td>
<td><strong>Other copay/coinsurance</strong></td>
</tr>
<tr>
<td>$20/20%</td>
<td>$20/20%</td>
<td>$20/20%</td>
</tr>
</tbody>
</table>

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**: $12,800

In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>What isn't covered</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductibles</strong>*</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Copayments</strong></td>
<td>$300</td>
</tr>
<tr>
<td><strong>Coinsurance</strong></td>
<td>$0</td>
</tr>
<tr>
<td><strong>Limits or exclusions</strong></td>
<td>$60</td>
</tr>
<tr>
<td><strong>The total Peg would pay is</strong></td>
<td><strong>$360</strong></td>
</tr>
</tbody>
</table>

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**: $7,400

In this example, Joe would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>What isn't covered</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductibles</strong>*</td>
<td>$20</td>
</tr>
<tr>
<td><strong>Copayments</strong></td>
<td>$700</td>
</tr>
<tr>
<td><strong>Coinsurance</strong></td>
<td>$0</td>
</tr>
<tr>
<td><strong>Limits or exclusions</strong></td>
<td><strong>$400</strong></td>
</tr>
</tbody>
</table>

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**: $1,900

In this example, Mia would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>What isn't covered</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductibles</strong>*</td>
<td>$100</td>
</tr>
<tr>
<td><strong>Copayments</strong></td>
<td>$80</td>
</tr>
<tr>
<td><strong>Coinsurance</strong></td>
<td>$200</td>
</tr>
<tr>
<td><strong>Limits or exclusions</strong></td>
<td>$0</td>
</tr>
<tr>
<td><strong>The total Mia would pay is</strong></td>
<td><strong>$380</strong></td>
</tr>
</tbody>
</table>

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: AlabamaBlue.com/b2020BlueChoicePlatinum.

*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

The plan would be responsible for the other costs of these EXAMPLE covered services.
Language Access Services and Notice of Nondiscrimination only apply to administrative services that Blue Cross and Blue Shield of Alabama provides to your employer.

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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.


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)


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)。