# Regions Medical Plan: Core Option

**Coverage Period: 01/01/2018 – 12/31/2018**

**Summary of Benefits and Coverage:** What this Plan Covers & What You Pay For Covered Services **Coverage for:** All Coverage Categories | **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, [insert contact information]. 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 benefits.regions.com or call 1-877-562-8383, option 1 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | **$ 2000** Single/**$2,700** Individual/ **$6000 family**<br>Doesn't apply to preventive services and certain other services when using participating providers | You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services that are subject to the deductible. See the Summary of Benefits or Summary Plan Description to check to see if specific services are subject to the deductible. The deductible starts over on January 1st of each year for this plan. See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible.** |
| **Are there services covered before you meet your deductible?** | Yes. | Preventive services are not subject to the deductible. |
| **Are there other deductibles for specific services?** | Yes. **$500** per admission deductible for inpatient hospitalization. There are no other specific **deductibles.** | 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. |
| **What is the out-of-pocket limit for this plan?** | **Medical: $3250** person / **$9750** family; **Prescription Drug: $3300** person/**$3300** family includes **deductibles** and **copayments.**. | 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 maximum helps you plan for health care expenses. **Deductibles**, **copayments** and **coinsurance**, apply toward the **out-of-pocket limit** There is a separate **out-of-pocket limit** for prescription drugs. |
| **What is not included in the out-of-pocket limit?** | **Premiums**, **balanced billed** charges and services this plan does not cover. | 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 **www.bcbsal.com or call 1-888-850-3276** for a list of participating providers. | 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 terms 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 you 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. You will most likely have to pay higher out-of-pocket costs if you see a non-network specialist. See the Summary Plan Description for details on in-network versus out-of-network costs. |
|---|---|---|

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 | 25% coinsurance | 55% coinsurance | Subject to deductible. |
| | Specialist visit | 25% coinsurance | 55% coinsurance | Subject to deductible. |
| | Chiropractor | 25% coinsurance for chiropractor. | 25% coinsurance for chiropractor | Chiropractic care is limited to 30 visits per person per calendar year. Subject to the deductible. |
| | Preventive care/screening/ immunization | No charge | Not covered | Limited to specific services. See the Preventive Services listing for details. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 25% coinsurance | 55% coinsurance | Subject to deductible. Limited to specific services. |
| | Imaging (CT/PET scans, MRIs) | 25% coinsurance | 55% coinsurance | Subject to the deductible. Pre-certification is required. Call 1-866-803-8002. If pre-certification is not obtained, no benefits are available. |

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Released on April 6, 2016

| 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 benefits.regions.com or by calling 1-800-391-1886. | Tier 1 (usually generic drugs) | $15 copay per prescription retail or $30 per prescription mail order | Not covered.<br><br>Note: CVS is a non-preferred network provider, co-pay is an additional | Covers up to a 30-day supply at retail or up to a 90-day supply for mail order. Pre-authorization and quantity limits may apply. See www.bcbsal.com for details. Subject to the deductible. SourceRX 1.0 formulary applies. |
| | Tier 2 (usually preferred drugs) | $30 copay per prescription retail or $60 per prescription mail order | Not covered.<br><br>Note: CVS is a non-preferred network provider, co-pay is an additional $10 | Covers up to a 30-day supply at retail or up to a 90 day supply for mail order. Required generics: member responsible for full cost of brand name drug when there is a generic equivalent. Pre-authorization and quantity limits may apply. See www.bcbsal.com for details. Subject to the deductible. SourceRX 1.0 formulary applies. |
| | Tier 3 (usually non-preferred drugs) | 10% (minimum $60; maximum $150) co-pay per prescription or 10% (minimum $120; maximum $300) co-pay per prescription | Not covered.<br><br>Note: CVS is a non-preferred network provider, co-pay is an additional $10 | Covers up to a 30-day supply at retail or up to a 90-day supply for mail order. Required generics: member responsible for full cost of brand name drug when there is a generic equivalent. Pre-authorization and quantity limits may apply. See www.bcbsal.com for details. Subject to the deductible. SourceRX 1.0 formulary applies. |
| | Specialty drugs | $30 Tier 2 or 10% (minimum $60; maximum $150) co-pay per prescription | Not covered. | You may be required to use a Specialty Pharmacy. Pre-authorization and quantity limits may apply. See www.bcbsal.com for details. Subject to deductible. SourceRX 1.0 formulary applies. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 25% coinsurance | 55% coinsurance | In Alabama, outpatient benefits for non-network hospitals are available only in cases of accidental injury. Subject to deductible. Pre-certification may be required. Call 1-800-248-2342. |
| | Physician/surgeon fees | 25% coinsurance | 55% coinsurance | Subject to deductible. |
| **If you need immediate medical attention** | Emergency room care | 25% coinsurance | 25% coinsurance | Emergency hospital admissions require pre-certifications within 48 hours. Subject to |

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| 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) | |
| | | | | deductible. Call 1-800-248-2342. |
| | Emergency medical transportation | Not Available | 25% coinsurance | Subject to deductible. Out-of-network charges may apply. |
| | Urgent care | 25% coinsurance | 25% coinsurance | Subject to deductible. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 25% coinsurance | 55% coinsurance | Subject to per admission deductible. Hospitalizations and some inpatient services require pre-certification. Call 1-800-248-2342. |
| | Physician/surgeon fees | 25% coinsurance | 55% coinsurance | Subject to the deductible. |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | 25% coinsurance | 55% coinsurance | Subject to the deductible. Some services require pre-certification. Call 1-800-248-2342. |
| | Inpatient services | 25% coinsurance | 55% coinsurance | Subject to per admission deductible. Requires pre-certification. Call 1-800-248-2342. |
| **If you are pregnant** | Office visits | 25% coinsurance | 55% coinsurance | Subject to deductible. |
| | Childbirth/delivery professional services | 25% coinsurance | 55% coinsurance | Subject to per admission deductible. |
| | Childbirth/delivery facility services | 25% coinsurance | 55% coinsurance | Subject to per admission deductible. |
| **If you need help recovering or have other special health needs** | Home health care | 25% coinsurance | 55% coinsurance<br>Not Covered out-of-network in Alabama | Subject to the deductible. Pre-certification is required. Call 1-800-821-7231. |
| | Rehabilitation services | 25% coinsurance | 25% coinsurance | Subject to the deductible. Limited to 30 visits combined per person per calendar year. |
| | Habilitation services | 25% coinsurance | 25% coinsurance | Subject to the deductible. Limited to 30 visits combined per person per calendar year. |
| | Skilled nursing care | Not covered | Not covered | Not Covered |
| | Durable medical equipment | 25% coinsurance | Not covered | Subject to the deductible |
| | Hospice services | 25% coinsurance | 55% coinsurance<br>Not Covered out of-network in Alabama | Subject to the deductible. Pre-certification is required. Call 1-800-821-7231. |
| **If your child needs dental or eye care** | Children's eye exam | Not Covered | Not Covered | Eye injury would be covered at 25% co-insurance per visit -subject to the deductible. Routine eye care is not covered under the |

| 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) | |
| | | | | health plan. A separate plan is available. |
| | Children's glasses | Not Covered | Not Covered | Not covered under the health plan. A separate plan is available. |
| | Children's dental check-up | Not Covered | Not Covered | Not covered under the health plan. A separate plan is available. |

**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.)**

- Accupuncture
- Cosmetic Surgery
- Dental Care
- Hearing Aids (Adults)
- Infertility Treatment
- Long Term Care
- Non-emergency care when traveling outside the U.S
- Private-duty Nursing
- Routine eye care
- Routine foot care
- Skilled nursing care, and
- 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
- Chiropractic Care

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. You may contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 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: Blue Cross Blue Shield of Alabama at 1-888-850-3276.

**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 the 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.

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146
Released on April 6, 2016

**Language Access Services:**

[Spanish (Español): Para obtener asistencia en Español, llame al 1-855-216-3144 [TTY711]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-216-3144 [TTY 711]
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-855-216-3144 [TTY 711].]

*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*

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## 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** **$2,000**
- **Specialist *[cost sharing]*** **$0/25%**
- **Hospital (facility) *[cost sharing]*** **$0/25%**
- **Other *[cost sharing]*** **$30/25%**

**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:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $2,000 |
| Copayments | $500 |
| Coinsurance | $1,300 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$3,360** |

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

- **The plan's overall deductible** **$2,000**
- **Hospital (facility) *[cost sharing]*** **$0/25%**
- **Other *[cost sharing]*** **$0/25%**

**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:**

| *Cost Sharing* | |
|---|---|
| Deductibles | 2,000 |
| Copayments | $700 |
| Coinsurance | $90 |
| *What isn't covered* | |
| Limits or exclusions | $400 |
| **The total Joe would pay is** | **$3,190** |

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

- **The plan's overall deductible** **$2,000**
- **Specialist *[cost sharing]*** **$0/25%**
- **Hospital (facility) *[cost sharing]*** **$0/25%%**
- **Other *[cost sharing]*** **$30/25%**

**This EXAMPLE event includes services like:**
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

| **Total Example Cost** | **$1,900** |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $1,900 |
| Copayments | $0 |
| Coinsurance | 40 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,900** |

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

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| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | **$ 1000** person **/ $3000 family** Doesn't apply to physician office visits; preventive services and certain other services when using participating providers. | You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services that are subject to the deductible. See the Summary of Benefits or Summary Plan Description to check to see if specific services are subject to the deductible. The deductible starts over on January 1st of each year for this plan. See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible.** |
| **Are there services covered before you meet your deductible?** | Yes. | Office visits and preventive services are not subject to the deductible. Only certain services are subject to the deductible and those are indicated within this document and in the Summary Plan Description. |
| **Are there other deductibles for specific services?** | Yes. **$300** per admission deductible for inpatient hospitalization and **$150** per person /Max of 3 per family for prescription drug coverage. There are no other specific **deductibles.** | 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. |
| **What is the out-of-pocket limit for this plan?** | **Medical: $2000** person **/ $6000** family; **Prescription Drug: $3300** person/**$6600** family includes **deductibles** and **copayments**. | 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 maximum helps you plan for health care expenses. **Deductibles**, **copayments** and **coinsurance**, apply toward the **out-of-pocket limit** There is a separate **out-of-pocket limit** for prescription drugs. |
| **What is not included in the out-of-pocket limit?** | **Premiums**, **balanced billed** charges and services this plan does not cover. | 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 **www.bcbsal.com or call 1-888-850-3276** for a list of participating providers. | 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 terms 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 you 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. You will most likely have to pay higher out-of-pocket costs if you see a non-network specialist. See the Summary Plan Description for details on in-network versus out-of-network costs. |

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 | $35 copay/visit | 30% coinsurance | Subject to deductible for out-of-network charges. |
| | Specialist visit | $60 copay/visit | 30% coinsurance | Subject to deductible for out-of-network charges. |
| | Chiropractor | 10% coinsurance for chiropractor. | 10% coinsurance for chiropractor | Chiropractic care is limited to 30 visits per person per calendar year. Subject to the deductible. |
| | Preventive care/screening/ immunization | No charge | Not covered | Limited to specific services. See the Preventive Services Listing for details. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 10% coinsurance | 30% coinsurance | Subject to deductible for out-of-network charges. Limited to specific services. |
| | Imaging (CT/PET scans, MRIs) | 10% coinsurance | 30% coinsurance | Pre-certification is required. Call 1-866-803-8002. If pre-certification is not obtained, no benefits are available. |

| 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 benefits.regions.com or by calling 1-800-391-1886. | Tier 1 (usually generic drugs) | $15 copay per prescription retail or $30 per prescription mail order | Not covered.<br><br>Note: CVS is a non-preferred network provider, co-pay is an additional $5 | Covers up to a 30-day supply at retail or up to a 90-day supply for mail order. Pre-authorization and quantity limits may apply. See www.bcbsal.com for details. Subject to prescription drug deductible. SourceRX 1.0 formulary applies. |
| | Tier 2 (usually preferred drugs) | $30 copay per prescription retail or $60 per prescription mail order | Not covered.<br><br>Note: CVS is a non-preferred network provider, co-pay is an additional $10 | Covers up to a 30-day supply at retail or up to a 90 day supply for mail order. Required generics: member responsible for full cost of brand name drug when there is a generic equivalent. Pre-authorization and quantity limits may apply. See www.bcbsal.com for details. Subject to prescription drug deductible. SourceRX 1.0 formulary applies. |
| | Tier 3 (usually non-preferred drugs) | 10% (minimum $60; maximum $150) co-pay per prescription or 10% (minimum $120; maximum $300) co-pay per prescription | Not covered.<br><br>Note: CVS is a non-preferred network provider, co-pay is an additional $10 | Covers up to a 30-day supply at retail or up to a 90-day supply for mail order. Required generics: member responsible for full cost of brand name drug when there is a generic equivalent. Pre-authorization and quantity limits may apply. See www.bcbsal.com for details. Subject to prescription drug deductible. SourceRX 1.0 formulary applies. |
| | Specialty drugs | $30 Tier 2 or 10% (minimum $60; maximum $150) co-pay per prescription | Not covered. | You may be required to use a Specialty Pharmacy. Pre-authorization and quantity limits may apply. See www.bcbsal.com for details. Subject to deductible. SourceRX 1.0 formulary applies. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 10% coinsurance | 30% coinsurance | In Alabama, outpatient benefits for non-network hospitals are available only in cases of accidental injury. Subject to deductible. Pre-certification may be required. Call 1-800-248-2342. |
| | Physician/surgeon fees | 10% coinsurance | 30% coinsurance | Subject to deductible for out-of-network charges. |

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| 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 immediate medical attention** | Emergency room care | 10% coinsurance | 10% coinsurance | Emergency hospital admissions require pre-certifications within 48 hours. Subject to deductible. Call 1-800-248-2342. |
| | Emergency medical transportation | Not available | 10% coinsurance | Subject to deductible. Out-of-network charges may apply. |
| | Urgent care | 10% coinsurance | 10% coinsurance | Subject to deductible. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 10% coinsurance | 30% coinsurance | Subject to per admission deductible. Hospitalizations and some inpatient services require pre-certification. Call 1-800-248-2342. |
| | Physician/surgeon fees | No charge | 30% coinsurance | ----------none---------- |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $60 copay/visit | 30% coinsurance | Subject to the deductible for out-of-network charges. Some services require pre-certification. |
| | Inpatient services | 10% coinsurance | 30% coinsurance | Subject to per admission deductible. Requires pre-certification. Call 1-800-248-2342. |
| **If you are pregnant** | Office visits | $30 copay/visit | 30% coinsurance | For diagnosis visit only; thereafter no copay. Subject to deductible for out-of-network charges. |
| | Childbirth/delivery professional services | 10% coinsurance | 30% coinsurance | Subject to per admission deductible. |
| | Childbirth/delivery facility services | 10% coinsurance | 30% coinsurance | Subject to per admission deductible. |
| **If you need help recovering or have other special health needs** | Home health care | 10% coinsurance | 30% coinsurance<br>Not Covered out-of-network in Alabama | Subject to the deductible. Pre-certification is required. Call 1-800-821-7231. |
| | Rehabilitation services | 10% coinsurance | 10% coinsurance | Subject to the deductible. Limited to 30 visits combined per person per calendar year. |
| | Habilitation services | 10% coinsurance | 10% coinsurance | Subject to the deductible. Limited to 30 visits combined per person per calendar year. |

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| 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) | |
| | Skilled nursing care | Not covered | Not covered | Not Covered |
| | Durable medical equipment | 10% coinsurance | Not covered | Subject to the deductible |
| | Hospice services | 10% coinsurance | 30% coinsurance<br>Not Covered out of-network in Alabama | Subject to the deductible. Pre-certification is required. Call 1-800-821-7231. |
| **If your child needs dental or eye care** | Children's eye exam | Not Covered | Not Covered | Eye injury would be covered at a $60 copay per visit. Routine eye care is not covered under the health plan. A separate plan is available. |
| | Children's glasses | Not Covered | Not Covered | Not covered under the health plan. A separate plan is available. |
| | Children's dental check-up | Not Covered | Not Covered | Not covered under the health plan. A separate plan is available. |

**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.)**

- Accupuncture
- Cosmetic Surgery
- Dental Care
- Hearing Aids (Adults)
- Infertility Treatment
- Long Term Care
- Non-emergency care when traveling outside the U.S
- Private-duty Nursing
- Routine eye care
- Routine foot care
- Skilled nursing care, and
- 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
- Chiropractic Care
-

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. You may contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 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: Blue Cross Blue Shield of Alabama at 1-888-850-3276.

**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 the 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.

**Language Access Services:**

[Spanish (Español): Para obtener asistencia en Español, llame al 1-855-216-3144 [TTY711]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-216-3144 [TTY 711]
[Chinese (中文): 如果需要中文的帮助， 请拨打这个号码 1-855-216-3144 [TTY 711].]

If you aren't clear about any of the terms used in this form, see the Uniform Glossary. You can view the Uniform Glossary in the "Documents and Forms" section of benefits.regions.com or call 1-877-562-8383, Option 1 to request a copy.

*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146
Released on April 6, 2016

## 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 *[cost sharing]*** **$60/0%**
- **Hospital (facility) *[cost sharing]*** **$0/10%**
- **Other *[cost sharing]*** **$60/10%**

**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:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $40 |
| Copayments | $300 |
| Coinsurance | $1,200 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$1,600** |

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

- **The plan's overall deductible** **$1,000/0%**
- **Hospital (facility) *[cost sharing]*** **$0/10%**
- **Other *[cost sharing]*** **$60/10%**

**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:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $200 |
| Copayments | $1,000 |
| Coinsurance | $60 |
| *What isn't covered* | |
| Limits or exclusions | $400 |
| **The total Joe would pay is** | **$1,660** |

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

- **The plan's overall deductible** **$1,000**
- **Specialist *[cost sharing]*** **$60/0%**
- **Hospital (facility) *[cost sharing]*** **$0/10%%**
- **Other *[cost sharing]*** **$60/10%**

**This EXAMPLE event includes services like:**
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

| **Total Example Cost** | **$1,900** |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $1,000 |
| Copayments | $200 |
| Coinsurance | $40 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,240** |

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