



2026 Ben E. Keith Company Annual Notices

The Ben E. Keith Company Welfare Benefit Plan 501 and the Retirement Plan 001 provide coverage and benefits that comply with applicable federal and state laws. Several of those laws require that we provide you with a summary of your rights each year.

These Notices are included in the following pages:

2026 Medicare Part D Prescription Drug Notice	Page 2
Women's Health and Cancer Rights	Page 3
Newborns' and Mothers' Health Protection	Page 3
HIPAA Special Enrollment Rights	Page 3
Children's Health Insurance Program (CHIP)	Page 4
Summary Annual Report for the Company Welfare Benefit Plan	Page 6
Summary Annual Report for the Retirement Savings Plan	Page 7

We're also reminding you of other important Notices you have already received or that are contained in this document, including:

Continuation Coverage Rights under COBRA	Page 5
HIPAA Privacy and Security	Page 5
Social Security Numbers of Family Members	Page 5
Summary of Benefits and Coverage	Page 5
BCBS of Alabama Summary of Benefits and Coverage	Page 8-14

Please review this information and keep it with your other important benefits communications. This information is always available on the Ben E. Keith Company benefits website at bek.family in **Resources > Plan documents & policies**.

For more information, contact the Corporate Benefits Team at benefits@benekeith.com.

IMPORTANT INFORMATION ABOUT YOUR BEN E. KEITH PRESCRIPTION DRUG COVERAGE AND MEDICARE

2026 NOTICE OF CREDITABLE COVERAGE: BCBS MEDICAL PLAN

Please read this Notice carefully, as this Notice has information about prescription drug coverage under the BCBS Medical Plan (the “BCBS Medical Plan”) and about your options under Medicare’s prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this Notice.

There are two important things you need to know about BCBS Medical Plan coverage and Medicare’s prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Ben E. Keith has determined that the prescription drug coverage offered by the BCBS Medical Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because the BCBS Medical Plan coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th. However, if you lose your BCBS Medical Plan creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage if You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your Company coverage will not be affected. For most persons covered under the BCBS Medical Plan, the BCBS Medical Plan will pay prescription drug benefits first, and Medicare will determine its payments second. For more information about which plan pays first and which plan pays second, see the Ben E. Keith Company Summary Plan Description (SPD) for Southeast Division and KVPC Southeast or contact Medicare.

If you decide to join a Medicare drug plan and drop your current coverage, you may be able to re-enroll in a Ben E. Keith medical plan during a future Annual Enrollment or within 31 calendar days following a qualified life event.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your BCBS Medical Plan coverage and don’t join a Medicare drug plan within 63 continuous days after your coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information about This Notice or Your Current Prescription Drug Coverage...

See the Ben E. Keith Company Summary Plan Description (SPD) for Southeast Division and KVPC Southeast or contact the Corporate Benefits Team at benefits@benekeith.com. **Note:** You’ll receive this Notice each year and if your medical coverage changes You can find a copy of this Notice any time in the **Resources** section of bek.family.

For More Information about Your Options under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the “Medicare & You” handbook. You’ll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

- Visit medicare.gov.
- Call your State Health Insurance Assistance Program for personalized help. Find your state’s number on the inside back cover of your copy of the “Medicare & You” handbook.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security at socialsecurity.gov or call them at 1-800-772-1213 (TTY 1-800-325-0778).

IMPORTANT! Keep this **2026 Notice of Creditable Coverage**. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this Notice when you join to show whether or not you maintained creditable coverage and, therefore, whether or not you must pay a higher premium (a penalty).

Date of this Notice: October 1, 2025

Name of Entity: Ben E. Keith Company

Corporate Benefits Team: benefits@benekeith.com

WOMEN'S HEALTH AND CANCER RIGHTS

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998.

For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed,
- Surgery and reconstruction of the other breast to produce a symmetrical appearance,
- Prostheses, and
- Treatment of physical complications of the mastectomy, including lymphedema.

This coverage will be subject to the provisions, limitations, exclusions, deductibles and coinsurance that apply to other medical and surgical benefits provided under the Ben E. Keith medical option. For more information, refer to your Summary Plan Description (SPD) in the **Resources > Plan documents & policies** section of bek.family or call Blue Cross Blue Shield of Alabama at 1-800-292-8868.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION

Under the Newborns' and Mothers' Health Protection Act of 1996, group health plans generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).

In addition, plans may not require that a provider obtain prior authorization from the plan for prescribing a length of stay not in excess of 48 hours (or 96 hours).

For more information, refer to your Summary Plan Description (SPD) in the **Resources > Plan documents & policies** section of bek.family or call Blue Cross Blue Shield of Alabama at 1-800-292-8868.

HIPAA SPECIAL ENROLLMENT RIGHTS

If you decline enrollment in Ben E. Keith medical coverage for yourself or your eligible family members (your spouse and children) because you have other health insurance or group health plan coverage, you may be able to enroll yourself and your eligible family members in a Ben E. Keith medical plan if you or your family member(s) lose eligibility for that other coverage (or if the employer stops contributing toward your or your family members' other coverage). However, **you must request enrollment within 31 calendar days** after your or your family members' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new family member as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your eligible family members in a Ben E. Keith medical option, provided you are eligible. However, **you must request enrollment within 31 calendar days** after the marriage, birth, adoption or placement for adoption.

If coverage is lost under your State Medicaid or a Children's Health Insurance Program (CHIP) plan, or you become eligible for premium assistance under your State Medicaid or CHIP plan, you may be able to enroll yourself and your eligible family members in a Ben E. Keith medical plan. **You must request enrollment within 60 calendar days** of the date of the event. (See the "Children's Health Insurance Program (CHIP)" Notice for more information.)

To request special enrollment, see your HR Manager or contact the Corporate Benefits Team at benefits@benekeith.com.

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state listed below, contact your state Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or visit insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under the Ben E. Keith medical plan, we must allow you to enroll if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 calendar days of being determined eligible for premium assistance.

If you have questions about enrolling in a Ben E. Keith medical plan, see your HR Manager or contact the Corporate Benefits Team at 1-817-877-5700. You can also contact the Department of Labor at askebsa.dol.gov or call 1-866-444-EBSA (3272). If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2025. Contact your state for more information on eligibility.

Alabama – Medicaid

<http://myalhipp.com/>
1-855-692-5447

Arkansas – Medicaid

<http://myarhipp.com/>
1-855-MyARHIPP (855-692-7447)

Colorado – Medicaid and CHIP+

Health First Colorado: <http://www.healthfirstcolorado.com/>
1-800-221-3943/State Relay 711
CHIP+: <https://hcpf.colorado.gov/child-health-plan-plus>
1-800-359-1991/State Relay 711
Health Insurance Buy-In: <https://www.mycohibi.com>
1-855-692-6442

Florida – Medicaid

<https://www.flmedicaidtprecovery.com/flmedicaidtprecovery.com/hipp/index.html>
1-877-357-3268

Georgia – Medicaid

<https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp>
1-678-564-1162, Press 1
CHIPRA: <https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra>
1-678-564-1162, Press 2

Kansas – Medicaid

<http://www.kancare.ks.gov>
1-800-792-4884
HIPP phone: 1-800-967-4660

Louisiana – Medicaid

<http://www.medicaid.la.gov> or <http://www.ldh.la.gov/lahipp>
1-888-342-6207 (Medicaid)
1-855-618-5488 (LaHIPP)

Missouri – Medicaid

<http://www.dss.mo.gov/mhd/participants/pages/hipp.htm>
1-573-751-2005

North Carolina – Medicaid

<https://medicaid.ncdhhs.gov/>
1-919-855-4100

Oklahoma – Medicaid and CHIP

<http://www.insureoklahoma.org>
1-888-365-3742

South Carolina – Medicaid

<https://www.scdhhs.gov>
1-888-549-0820

Texas – Medicaid

<https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program>
1-800-440-0493

To see if any other states have added a premium assistance program since July 31, 2025, or for more information on special enrollment rights, contact either:

U.S. Department of Labor Employee Benefits Security Administration
www.dol.gov/agencies/ebsa or call 1-866-444-EBSA (3272)

or

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov or call 1-877-267-2323, Menu Option 4, Ext. 61565

IMPORTANT REMINDER: REVIEW NOTICES YOU HAVE ALREADY RECEIVED

CONTINUATION COVERAGE RIGHTS UNDER COBRA

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end.

For more information about your rights and obligations under the Plan and under federal law, review the COBRA Rights Notice that was provided to you when you first became eligible. You can also find information in the Plan's Summary Plan Description (SPD) in the **Resources > Plan documents & policies** section of bek.family or by contacting your HR Manager or Office Manager.

HIPAA PRIVACY AND SECURITY

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires health plans to comply with privacy rules. These rules are intended to protect your personal health information from being inappropriately used and disclosed. The rules also give you additional rights concerning control of your own health care information.

The Ben E. Keith Company HIPAA Notice of Privacy Practices explains how the Ben E. Keith Company Welfare Benefit Plan may and may not use and share your protected health information and how you can exercise your health privacy rights. It also explains our obligation to notify you following a breach of unsecured protected health information. We're required to notify you of the availability of this Notice every three years.

For a copy of the most recent Notice, go to the **Resources > Plan documents & policies** section of bek.family or contact the Corporate Benefits Team at benefits@benekeith.com.

SOCIAL SECURITY NUMBERS OF FAMILY MEMBERS

We're required by law to collect the Social Security number (or other taxpayer identification number) of each family member who enrolls in a Ben E. Keith medical plan and report that information to the Internal Revenue Service each year.

If a family member does not yet have a Social Security number (for example, a newborn child), you can request one from the Social Security Administration by visiting <https://www.ssa.gov/forms/ss-5.pdf>. Applying for a Social Security number is free.

If you have not yet provided the Social Security number (or other taxpayer identification number) for each of your enrolled family members, please add it to your information when enrolling during Annual Enrollment or when requesting coverage for a family member following a qualified status change. If there are delays in getting a Social Security number, please see your HR Manager or contact the Corporate Benefits Team at benefits@benekeith.com.

SUMMARY OF BENEFITS AND COVERAGE (SBC)

We're required to provide you with an SBC for the medical plan option each year during Annual Enrollment. The SBC describes the benefits available to you, in a prescribed format, so you can easily compare your Ben E. Keith medical option to other plans that may be available to you, including individual coverage offered through the Health Insurance Marketplace.

The 2026 SBC for the Ben E. Keith Blue Cross Blue Shield of Alabama Medical Plan are included on pages 8-14 of this document. If you have questions about these summaries, or want an additional copy, go to the **Resources > Plan documents & policies** section of bek.family or contact the Benefits Team at benefits@benekeith.com.



2024 SUMMARY ANNUAL REPORT FOR BEN E. KEITH COMPANY WELFARE BENEFIT PLAN

This is a summary of the annual report of the Ben E. Keith Company Welfare Benefit Plan, EIN 75-0372230, Plan No. 502, for the period January 1, 2024 through December 31, 2024. The annual report has been filed with the Employee Benefits Security Administration, U.S. Department of Labor, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

Ben E. Keith Company has committed itself to pay certain self-insured medical, stop loss and short-term disability claims incurred under the terms of the Plan.

Insurance Information

The Plan has contracts with Cigna Health and Life Insurance Company and Affiliates (dental); Metropolitan Life Insurance Company (vision); Blue Cross Blue Shield of Alabama (BCBS medical); and Lincoln National Life Insurance Company (employee, spouse and child life/AD&D) to pay medical, dental, vision and life/AD&D claims incurred under the terms of the Plan. The total premiums paid for the plan year ending December 31, 2024 were \$12,844,601.

Because they are so called “experience-rated” contracts, the premium costs are affected by, among other things, the number and size of claims. Of the total insurance premiums paid for the plan year ending December 31, 2024, the premiums paid under such “experience-rated” contracts were \$4,447,426 and the total of all benefit claims paid under these contracts during the plan year was \$3,438,765.

Your Rights To Additional Information

You have the right to receive a copy of the full annual report, or any part thereof, on request. The report includes insurance information, including sales commissions paid by insurance carriers.

To obtain a copy of the full annual report, or any part thereof, write Ben E. Keith Company at 601 East 7th Street, Fort Worth, TX 76102, or contact the Corporate Benefits Team at benefits@benekeith.com.

You also have the legally protected right to examine the annual report at the main office of the plan (Ben E. Keith Company, 601 East 7th Street, Fort Worth, TX 76102) and at the U.S. Department of Labor in Washington, D.C., or to obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the Department should be addressed to:

Public Disclosure Room N1513
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, N.W.
Washington, D.C. 20210



2024 SUMMARY ANNUAL REPORT BEN E. KEITH RETIREMENT SAVINGS PLAN

This is a summary of the annual report for the Ben E. Keith Retirement Savings Plan (Employer Identification Number 75-0372230, Plan Number 002) for the plan year July 1, 2023 through June 30, 2024. The annual report has been filed with the Employee Benefits Security Administration, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

Basic Financial Statement

Benefits under the Plan are provided by a trust fund. Plan expenses were \$23,483,271. These expenses included \$403,388 in administrative expenses and \$22,819,413 in benefits paid to participants and beneficiaries, and \$260,470 in other expenses. A total of 7,473 persons were participants in or beneficiaries of the Plan at the end of the Plan year, although not all of these persons had yet earned the right to receive benefits.

The value of Plan assets, after subtracting liabilities of the Plan, was \$400,527,407 as of the end of the plan year, compared to \$313,321,603 as of the beginning of the Plan year. During the Plan year, the Plan experienced a change in its net assets of \$87,205,804. This change includes unrealized appreciation or depreciation in the value of plan assets; that is, the difference between the value of the Plan's assets at the end of the year and the value of the assets at the beginning of the year or the cost of assets acquired during the year. The Plan had total income of \$110,689,075, including employer contributions of \$29,681,351, employee contributions of \$32,247,521, other contributions/other income of \$3,670,515, and earnings from investments of \$45,089,688.

Your Rights to Additional Information

You have the right to receive a copy of the full annual report, any part thereof, on request. The report includes an accountant's report, financial information and information on payments to service providers, assets held for investment, and information regarding any common or collective trusts, pooled separate accounts, master trusts or 103-12 investment entities in which the Plan participates.

To obtain a copy of the full annual report, or any part thereof, write the Ben E. Keith Company at 601 East 7th Street, Fort Worth, TX 76102, or call 1-817-877-5700.

You also have the right to receive from the Plan administrator, on request and at no charge, a statement of the assets and liabilities of the plan and accompanying notes, or a statement of income and expenses of the plan and accompanying notes, or both. If you request a copy of the full annual report from the Plan administrator, these two statements and accompanying notes will be included as part of that report.

You also have the legally protected right to examine the annual report at the main office of the Plan: 601 East 7th Street, Fort Worth, TX 76102, and at the U.S. Department of Labor in Washington, D.C., or to obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the Department should be addressed to:

Public Disclosure Room N-1513
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue N.W.
Washington, D.C. 20210



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. 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 1-855-350-7437 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: \$500 individual / \$1,000 family. Out-of-Network: \$1,000 individual / \$2,000.	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 healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	Yes. \$800 per admission for out-of-network. 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?	In-network: \$5,000 individual / \$10,000 family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums , balance-billing charges, health care this plan doesn't cover, cost sharing for most out-of-network benefits 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 1-800-810-BLUE for a list of network providers .	This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral .



All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-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. Deductible does not apply	20% coinsurance	In Alabama, out-of-network coinsurance is 50%; precertification is required for some provider administered drugs; if no precertification is obtained, no benefits are available.
	Specialist visit	\$50 copay /visit. Deductible does not apply	20% coinsurance	
	Preventive care/screening/Immunization	No charge. Deductible does not apply	Not Covered	Please visit alabamablue.com/preventiveservices . 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)	No Charge. Deductible does not apply.	20% coinsurance	Benefits listed are physician services; in Alabama, out-of-network coinsurance is 50%; facility benefits are also available; precertification may be required; if no precertification is obtained, no benefits are available.
	Imaging (CT/PET scans, MRIs)	\$200 copay /test. Deductible does not apply.	20% coinsurance	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at AlabamaBlue.com/pharmacy	Tier 1 Drugs	\$15 copay (retail) \$37.50 copay (mail order). Deductible does not apply.	Not Covered	Precertification is required for some drugs; if no precertification is obtained, no benefits are available; generic drugs mandatory when available; covered insulin products may have lower patient responsibility; select generic specialty and biosimilar drugs on the Select Generic Specialty and Biosimilar Drug List will have lower member cost share.
	Tier 2 Drugs	\$40 copay (retail) \$100 copay (mail order). Deductible does not apply.	Not Covered	
	Tier 3 Drugs	\$60 copay (retail) \$150 copay (mail order). Deductible does not apply.	Not Covered	
	Tier 4 Drugs	\$100 copay (retail) Deductible does not apply.	Not Covered	

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$200 <u>copay</u> . Deductible does not apply.	20% <u>coinsurance</u>	In Alabama, out-of-network not covered; precertification may be required; if no precertification is obtained, no benefits are available.
	Physician/surgeon fees	0% <u>coinsurance</u>	20% <u>coinsurance</u>	In Alabama, <u>out-of-network coinsurance</u> is 50%.
If you need immediate medical attention	<u>Emergency room care</u>	Accident: \$200 <u>copay</u> /visit. Deductible does not apply. Medical Emergency: \$200 <u>copay</u> /visit. Deductible does not apply.	Accident: \$200 <u>copay</u> /visit. Deductible does not apply. Medical Emergency: \$200 <u>copay</u> /visit. Deductible does not apply.	Physician charges will apply
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<u>Urgent care</u>	\$35 <u>copay</u> /visit. Deductible does not apply.	20% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	\$200 copay/day days 1-5. Deductible does not apply.	\$800 per admission deductible & 20% coinsurance.	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.
	Physician/surgeon fees	0% <u>coinsurance</u>	20% <u>coinsurance</u>	In Alabama, <u>out-of-network coinsurance</u> is 50%.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$50 copay/visit Deductible does not apply.	20% <u>coinsurance</u>	In Alabama, <u>out-of-network coinsurance</u> is 50% for professional services; precertification is required for intensive outpatient, partial <u>hospitalization</u> and <u>inpatient hospitalization</u> ; if no precertification is obtained, no benefits are available.
	Inpatient services	Physician: No Charge. Deductible does not apply Inpatient Hospital: \$200 copay/day days 1-5. Deductible does not apply	Physician: 20% <u>coinsurance</u> Deductible does not apply. Inpatient Hospital: \$800 per admission deductible & 20% coinsurance	
If you are pregnant	Office visits	0% <u>coinsurance</u>	20% <u>coinsurance</u>	Cost sharing does not apply for <u>preventive services</u> . Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound); in Alabama, <u>out-of-network coinsurance</u> is 50% for professional services; precertification may be required; if no precertification is obtained, no benefits are available.
	Childbirth/delivery professional services	0% <u>coinsurance</u>	20% <u>coinsurance</u>	
	Childbirth/delivery facility services	\$200 copay/day days 1-5. Deductible does not apply.	\$800 per admission deductible & 20% coinsurance.	
If you need help recovering or have other special health needs	Home health care	No charge. <u>Deductible</u> does not apply.	20% <u>coinsurance</u>	In Alabama, out-of-network not covered; benefits are also available for home infusion services; precertification may be required; if no precertification is obtained, no benefits are available.
	Rehabilitation services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Benefits listed are for <u>Rehabilitation & Habilitation</u> services; each service has a combined maximum of 30 visits for occupational, physical and speech therapy per year; in Alabama, <u>out-of-network coinsurance</u> is 50%; children ages 0-18 with an autistic diagnosis are allowed unlimited visits for occupational, physical and speech therapy.
	Habilitation services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	
	Skilled nursing care	Not Covered	Not Covered	Not covered; member pays 100%.
	Durable medical equipment	20% <u>coinsurance</u>	20% <u>coinsurance</u>	In Alabama, <u>out-of-network coinsurance</u> is 50%; precertification may be required; if no precertification is obtained, no benefits are available.
	Hospice services	No charge. <u>Deductible</u> does not apply.	20% <u>coinsurance</u>	In Alabama, out-of-network not covered; precertification may be required; if no precertification is 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)	Non-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	No charge. <u>Deductible</u> does not apply.	Not Covered	Please visit alabamablue.com/preventiveservices .
	Children's glasses	Not Covered	Not Covered	Not covered; member pays 100%.
	Children's dental check-up	No charge. <u>Deductible</u> does not apply.	Not Covered	Please visit alabamablue.com/preventiveservices .

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

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 Bariatric surgery Cosmetic surgery 	<ul style="list-style-type: none"> Dental care (adult) Glasses, child Hearing aids 	<ul style="list-style-type: none"> Long-term care Private-duty nursing Routine eye care (adult) 	<ul style="list-style-type: none"> 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.)			
<ul style="list-style-type: none"> Chiropractic care (limited to 15 visits per member per calendar year) 	<ul style="list-style-type: none"> Infertility treatment (Assisted Reproductive Technology not covered) 	<ul style="list-style-type: none"> Non-emergency care when traveling outside the U.S. 	

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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa, or BlueCross BlueShield of Alabama at 1-800-292-8868. 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 or your state insurance department.

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 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](#).

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



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	\$500
■ Specialist copayment	\$50
■ Hospital (facility) copayment	\$0
■ Other copayment/coinsurance	\$200/20%

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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles*	\$500
Copayments	\$400
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$960

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$500
■ Specialist copayment	\$50
■ Hospital (facility) copayment	\$0
■ Other copayment/coinsurance	\$200/20%

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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles*	\$200
Copayments	\$800
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$40
The total Joe would pay is	\$1,040

Mia's Simple Fracture

(in-network emergency room visit and follow-up care)

■ The plan's overall deductible	\$500
■ Specialist copayment	\$50
■ Hospital (facility) copayment	\$0
■ Other copayment/coinsurance	\$200/20%

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	\$2,800
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles*	\$500
Copayments	\$300
Coinsurance	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,000

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](#).

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

Language Access Services and Notice of Nondiscrimination only apply to administrative services that Blue Cross and Blue Shield of Alabama provides to your employer.

Language Access Services and Notice of Nondiscrimination

Blue Cross and Blue Shield of Alabama, an independent licensee of the Blue Cross and Blue Shield Association, 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.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

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)

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-216-3144 (TTY: 711)번으로 전화해 주십시오.

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)。

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-216-3144 (TTY: 711).

711: انتباه: إذا كنت تتحدث العربية، توجد خدمات مساعدة فيما يتعلق باللغة، بدون تكلفة، متاحة لك. اتصل بـ 1-855-216-3144 (الهاتف النصي: 711) : **Arabic**

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-216-3144 (TTY: 711).

French: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-216-3144 (ATS: 711).

French Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-855-216-3144 (TTY: 711).

Gujarati: ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હોય, તો ભાષા સહાયતા સેવા, તમારા માટે નિ:શુલ્ક ઉપલબ્ધ છે. 1-855-216-3144 પર કૉલ કરો (TTY: 711).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-216-3144 (TTY: 711).

Hindi: ध्यान दें: अगर आपकी भाषा हिंदी है, तो आपके लिए भाषा सहायता सेवाएँ नि:शुल्क उपलब्ध हैं। 1-855-216-3144 (TTY: 711) पर कॉल करें।

Laotian: ໄປດຊາບ: ຖ້າວ່າທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-855-216-3144 (TTY: 711).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-216-3144 (телетайп: 711).

Portuguese: ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-855-216-3144 (TTY: 711).

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-855-216-3144 (TTY: 711).

Turkish: DİKKAT: Eğer Türkçe konuşuyor iseniz, dil yardımı hizmetlerinden ücretsiz olarak yararlanabilirsiniz. 1-855-216-3144 (TTY: 711) irtibat numaralarını arayın.

Italian: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-216-3144 (TTY: 711).

Japanese: 注意事項: 日本語を話される場合、無料の言語支援をご利用いただけます。1-855-216-3144 (TTY: 711)まで、お電話にてご連絡ください。