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 Mercer Marketplace 365+ Benefits Center at +1 855-684-6628 to request a copy. 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 https://www.healthcare.gov/sbc-glossary or call Mercer Marketplace 365+ Benefits Center at +1 855-684-6628 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$200 individual / $600 family. Prescription drug copays do not count toward the deductible.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to play. 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 care and mail order prescription drugs are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$2,000 individual / $6,000 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, penalties for failure to obtain preauthorization for services, and health care this plan doesn't 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.alabamablue.com or call +1 833-994-0014 for a list of health care network providers. For a list of pharmacies that are network providers, see www.express-scripts.com or call 1-877-657-2496.	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.

Important Questions	Answers	Why This Matters:
Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	20% coinsurance	None
	Specialist visit	20% coinsurance	20% coinsurance	Chiropractic care limited to 30 visits per calendar year.
	Preventive care/screening/ immunization	No charge (up to the allowed amount)	No charge (up to the allowed amount)	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. Age and frequency schedules apply.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	20% coinsurance	Cost sharing does not apply for preventive care diagnostic tests
	Imaging (CT/PET scans, MRIs)	20% coinsurance	20% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com	Generic drugs	$10 copay/prescription retail, $20 copay/prescription mail order	Not covered	$2,500 annual maximum per individual. The maximum is based on the Plan's cost for the drugs Up to a 30-day supply retail, 90-day supply for mail order or Smart90 Program. Generic and brand contraceptives and specified preventive care drugs are covered at no charge. Preauthorization is required for certain prescriptions. No coverage for non-participating (out-of-network) pharmacy
	Preferred brand drugs	$25 copay/prescription retail, $50 copay/prescription mail order	Not covered	
	Non-preferred brand drugs	$45 copay/prescription retail, $90 copay/prescription mail order	Not covered	
	Specialty drugs	$20 copay/prescription for generic;	Not covered	Specialty drugs – Up to a 90-day supply. Copay is prorated based on days supplied. Specialty drugs can only be dispensed

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)	
		$50 copay/prescription for preferred brand; $90 copay/prescription for non-		through the Express Scripts specialty mail order pharmacy (Acredo).
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	20% coinsurance	None
	Physician/surgeon fees	20% coinsurance	20% coinsurance	None
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	Non-emergency use of ER covered at 50% coinsurance.
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	20% coinsurance	20% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	20% coinsurance	Preauthorization required or a $500 penalty may apply.
	Physician/surgeon fees	20% coinsurance	20% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	20% coinsurance	None
	Inpatient services	20% coinsurance	20% coinsurance	Preauthorization required or a $500 penalty may apply.
If you are pregnant	Office visits	20% coinsurance	20% coinsurance	Cost sharing does not apply for preventive care prenatal services. Applicable copay or coinsurance applies for any services not included as part of bundled maternity services.
	Childbirth/delivery professional services	20% coinsurance	20% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	20% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	20% coinsurance	120 visit limit per calendar year. Preauthorization required for care or a $500 penalty may apply.
	Rehabilitation services	20% coinsurance	20% coinsurance	Includes speech, physical and occupational therapy. Limited to speech therapy to restore speech resulting from sickness or injury and
	Habilitation services			

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)	
		20% coinsurance	320% coinsurance	applied behavioral analysis for individuals with an autism spectrum disorder diagnosis.
	Skilled nursing care	20% coinsurance	20% coinsurance	120 visit limit per calendar year. Preauthorization required for inpatient care or a $500 penalty may apply.
	Durable medical equipment	20% coinsurance	20% coinsurance	None
	Hospice services	20% coinsurance	20% coinsurance	180 days lifetime limit for inpatient care and 180 visits lifetime limit for outpatient care. Preauthorization required for out-of-network care or a $500 penalty may apply.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Separate vision plan available.
	Children's glasses	Not covered	Not covered	Separate vision plan available.
	Children's dental check-up	Not covered	Not covered	Separate vision plan 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.)

- Acupuncture (other than as anesthesia in connection with covered surgery)
- Cosmetic surgery
- Dental care (adult & child)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (adult & child) (screening exam covered if performed as part of routine physical exam)
- Routine foot care
- Weight loss programs (but weight loss drugs may be covered)

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

- Bariatric surgery (1 surgery limit per lifetime; preauthorization required for out-of-network care or a $500 penalty may apply)
- Chiropractic care (30 visit limit per calendar year)
- Hearing aids ($1,500 limit every 24 months)
- Infertility treatment preauthorization required to receive benefits; $17,500 lifetime limit
- Private-duty nursing (70 visit limit per calendar year; preauthorization required for out- of-network care or a $500 penalty may apply)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact BCBSAL 1-833-994-0014 or www.bcbsal.com) for medical claims and Express Scripts (1-877-657-2496 or www.express-scripts.com) for prescription drug claims. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet 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 1-833-994-0014.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-833-994-0014.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-833-994-0014.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-833-994-0014.

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

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$200
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	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**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$200
Copayments	$0
Coinsurance	$1,800
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,060**

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

The plan's overall deductible	$200
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	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**
In this example, Joe would pay:	
Cost Sharing	
Deductibles*	$200
Copayments	$500
Coinsurance	$300
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,020**

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

The plan's overall deductible	$200
Specialist copayment	20%
Hospital (facility) coinsurance	20%
Other coinsurance	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**
In this example, Mia would pay:	
Cost Sharing	
Deductibles*	$200
Copayments	$5
Coinsurance	$500
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$710**

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