This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at http://courthouse.jcc.jccal.org or by calling (205) 325-5249.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	From 10/01/2013 to 09/30/2014: **$200** person in-network. **$1000** person out-of-network. Does not apply to preventive services, physician, inpatient, drugs, non-covered services, balance-billed charges and pre-certification penalties.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. **$2000** person.	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 limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premium, balance-billed charges, health care this plan doesn't cover, deductibles and pre-certification penalties.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes, this plan uses in-network providers. For a list of in-network providers, see www.bcbsal.com or call 1-800-810-BLUE.	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 term 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 I 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.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**.

Questions: Call 1-800-810-BLUE or visit us at www.bcbsal.com.
If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call (205) 325-5249 to request a copy.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use an In Network Provider	Your cost if you use an Out of Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	0% coinsurance & $25 copay	50% coinsurance	Subject to overall deductible out-of-network; in-network copay waived when services are rendered at Cooper Green Mercy Health Services
	Specialist visit	0% coinsurance & $25 copay	50% coinsurance	Subject to overall deductible out-of-network; in-network copay waived when services are rendered at Cooper Green Mercy Health Services
	Other practitioner office visit	20% coinsurance for chiropractor	50% coinsurance for chiropractor	Subject to overall deductible
	Preventive care/screening/immunization	No Charge	Not Covered	Please visit www.bcbsal.compreventiveservices; additional services may be available
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	50% coinsurance	Benefits listed are physician services; subject to overall deductible for out-of-network

Common Medical Event	Services You May Need	Your cost if you use an In Network Provider	Your cost if you use an Out of Network Provider	Limitations & Exceptions
	Imaging (CT/PET scans, MRIs)	No Charge	50% coinsurance	Benefits listed are physician services; subject to overall deductible for out-of-network; precertification may be required for coverage
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at bcbsal.com/pharmacy.	Generic drugs	0% coinsurance & $5 copay	Not Covered	Prior authorization required for specific drugs; mail order is available through PrimeMail
	Preferred brand drugs	0% coinsurance & $40 copay	Not Covered	Prior authorization required for specific drugs; mail order is available through PrimeMail
	Non-preferred brand drugs	0% coinsurance & $90 copay	Not Covered	Prior authorization required for specific drugs; mail order is available through PrimeMail
	Specialty drugs	0% coinsurance & $90 copay	Not Covered	Prior authorization required for specific drugs; subject to preferred brand or non-preferred brand copay
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance & $100 copay	50% coinsurance	Subject to overall deductible for out-of-network; in Alabama, out-of-network not covered
	Physician/surgeon fees	No Charge	50% coinsurance	Subject to overall deductible for out-of-network
If you need immediate medical attention	Emergency room services	0% coinsurance & $150 copay	0% coinsurance & $150 copay	Physician charges may apply
	Emergency medical transportation	20% coinsurance	20% coinsurance	Subject to in-network overall deductible
	Urgent care	0% coinsurance & $25 copay	50% coinsurance	Subject to overall deductible for out-of-network; in-network copay waived when services are rendered at Cooper Green Mercy Health Services

Common Medical Event	Services You May Need	Your cost if you use an In Network Provider	Your cost if you use an Out of Network Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance & $100 copay days 1-3	50% coinsurance	Subject to overall deductible for out-of-network; in Alabama, out-of-network benefits are only available for accidental injury; precertification is required for coverage
	Physician/surgeon fee	No Charge	50% coinsurance	Subject to overall deductible for out-of-network
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$25 copay/visit for office visits, 20% coinsurance for outpatient	Not Covered	Office visits limited to 15 visits/year. Overall deductible does not apply.
	Mental/Behavioral health inpatient services	$100 copay days 1-3 for inpatient, 20% coinsurance for intensive outpatient	Not Covered	No coverage unless pre-authorized by Behavioral Health Systems (BHS) No coverage for services by out-of-network providers
	Substance use disorder outpatient services	20% coinsurance	Not Covered	Substance abuse rehabilitation benefits limited to one treatment episode per lifetime.
	Substance use disorder inpatient services	20% coinsurance for inpatient rehabilitation and intensive outpatient	Not Covered	Substance abuse rehabilitation benefits limited to one treatment episode per lifetime.
If you are pregnant	Prenatal and postnatal care	0% coinsurance & $25 copay	50% coinsurance	Benefits listed are outpatient physician services; subject to overall deductible for out-of-network; physician copay may apply
	Delivery and all inpatient services	No Charge	50% coinsurance	Benefits listed are inpatient physician services; subject to overall deductible for out-of-network

Common Medical Event	Services You May Need	Your cost if you use an In Network Provider	Your cost if you use an Out of Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No Charge	50% coinsurance	Subject to overall deductible for out-of-network; limited to a maximum of 60 visits per member per plan year; in Alabama, out-of-network not covered; precertification may be required for coverage
	Rehabilitation services	20% coinsurance	50% coinsurance	Subject to overall deductible; limited to 20 visits each for occupational, physical and speech therapy per member per plan year
	Habilitation services	20% coinsurance	50% coinsurance	Subject to overall deductible; limited to 20 visits each for occupational, physical and speech therapy per member per plan year
	Skilled nursing care	20% coinsurance	20% coinsurance	Subject to in-network overall deductible; limited to a maximum of 60 days per member per plan year
	Durable medical equipment	20% coinsurance	50% coinsurance	Subject to overall deductible
	Hospice service	No Charge	50% coinsurance	Subject to overall deductible for out-of-network; limited to a lifetime maximum of 180 days per member; in Alabama, out-of-network not covered; precertification may be required for coverage
If your child needs dental or eye care	Eye exam	No Charge	Not Covered	Please see www.bcbsal.com/preventiveservices
	Glasses	Not Covered	Not Covered	——————none——————
	Dental check-up	No Charge	Not Covered	Please see www.bcbsal.com/preventiveservices

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric Surgery
- Cosmetic surgery
- Dental care (Adult)
- Glasses, child
- Hearing aids
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Substance use disorder
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care
- Infertility treatment (limitations apply)
- Non-emergency care when traveling outside the U.S.

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.
For more information on your rights to continue coverage, contact the plan administrator at the phone number listed in your benefit booklet. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact Blue Cross and Blue Shield of Alabama at 1-800-810-BLUE. For mental health and substance abuse, contact Behavioral Health Systems (BHS) at 1-800-245-1150.

SPANISH (Español): Para obtener asistencia en Español, llame al 1-800-810-2583.

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $7,150
- **Patient pays** $390

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$240
Coinsurance	$0
Limits or exclusions	$150
Total	**$390**

Note: These numbers assume the patient has given notice of her pregnancy to the plan. If you are pregnant and have not given notice of your pregnancy, your costs may be higher. For more information, please contact: www.bcbsal.com.

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,280
- **Patient pays** $1,120

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$20
Copays	$730
Coinsurance	$0
Limits or exclusions	$370
Total	**$1,120**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: www.bcbsal.com.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.