Southern Energy Homes-Simple Plan

Coverage For: Individual + Family **Plan Type:** PPO

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 1-888-578-6772 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 1-800-292-8868 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For in-network: $0 For out of network $5,000 individual/$10,000 family out-of-network.	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes. In-network services 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 deductible for specific services.
What is the out–of–pocket limit for this plan?	For in-network $6,000 individual/$12,000 family. For out-of-network $10,000 individual/$20,000 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 limit until the overall family out-of-pocket limit has been met.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, health care this plan doesn't cover, pre-certification penalties and specialty drug manufacturer assistance amounts for provider-administered drugs.	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)	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	The lesser of the allowed amount or $40 copay/visit	40% coinsurance	The following office services are included in the in-network office visit copay when performed in the context of that office visit: minor surgeries, lab, pathology, standard radiology, low cost injections, and second surgical opinions; allergy serum provided at no charge. Psychiatrist visits, psychologist visits, and intensive outpatient services/partial hospitalization for mental health disorders are subject to the $40 in-network copay. Chemotherapy, Radiation, Dialysis and IV Therapy performed in an office setting are subject to a $250 copay.
	Specialist visit	The lesser of the allowed amount or $120 copay/visit	40% coinsurance	
	Preventive care/screening/ Immunization/office services	No Charge	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 (for example-standard radiology like an x-ray, ultrasound, etc.)	The lesser of the allowed amount or $90 copay/visit	40% coinsurance	When the diagnostic test is administered in the context of a physician office visit, emergency room visit, or inpatient stay; the diagnostic test is provided at no charge ($90 in-network copay does not apply). $90 in-network copay is inclusive of both facility and physician charges. Lab and pathology are provided at no charge ($90 in-network diagnostic test copay does not apply).
	Advanced Imaging (for example-CT/PET scans, MRIs, etc.)	The lesser of the allowed amount or $500 copay/visit	40% coinsurance	When the advanced imaging is administered in the context of an emergency room visit or inpatient stay, the advanced imaging is provided at no charge ($500 in-network copay does not apply). Precertification required for advanced imaging $500 in-network copay is inclusive of both facility and physician charges.

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 **www.express-scripts.com**	Tier 1 Drugs	The lesser of the allowed amount or $20 copay (retail/34-day supply) The lesser of the allowed amount or $50 copay (mail order/90-day supply)	Not Covered	Retail covers up to a 34-day supply or 90-day supply may be available at a network pharmacy; Mail Order covers a 90-day supply. Some drugs are not covered, require prior authorization or have supply limits. You may be required to try a lower cost drug before a non-preferred brand drug can be covered. Please see your policy or plan for a complete description of the pharmacy limitations and exceptions.
	Tier 2 Drugs	The lesser of the allowed amount or $120 copay (retail/34-day supply) The lesser of the allowed amount or $300 copay (mail order/90-day supply)	Not Covered	
	Tier 3 Drugs	The lesser of the allowed amount or $250 copay (retail/34-day supply) The lesser of the allowed amount or $625 copay (mail order/90-day supply)	Not Covered	
	Tier 4 Drugs	The lesser of the allowed amount or $250 copay (retail/34-day supply) The lesser of the allowed amount or $625 copay (mail order/90-day supply)	Not Covered	

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	The lesser of the allowed amount or $700 copay	40% coinsurance	Facility fee covers facility and physician services associated with an outpatient surgery, but other services (e.g., advanced imaging) would require additional copays. Example services included in this outpatient surgery category: interventional radiology, therapeutic radiology, diagnostic colonoscopies and bariatric surgery performed in an outpatient setting.
	Physician/surgeon fees	No Charge	No Charge	None
If you need immediate medical attention	Emergency room care	Accident: The lesser of the allowed amount or $1,000 copay/visit Medical Emergency: The lesser of the allowed amount or $1,000 copay/visit	Accident: The lesser of the allowed amount or $1,000 copay/visit No overall deductible Medical Emergency: The lesser of the allowed amount or $1,000 copay/visit No overall deductible	Includes 23 hour observation; copay waived if admitted; includes all services in the emergency room
	Emergency medical transportation	The lesser of the allowed amount or $700 copay/per trip	The lesser of the allowed amount or $700 copay/visit No overall deductible	Includes ground and air ambulance
	Urgent care	The lesser of the allowed amount or $75 copay/visit	40% coinsurance	Care provided in Urgent Care setting will incur copay according to provider type (e.g., primary care visit, specialist visit) unless claim is designated as Urgent Care services (e.g., afterhours / holiday care) in which case it will receive the Urgent Care copay

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 have a hospital stay	Facility fee (e.g., hospital room)	The lesser of the allowed amount or $1,500 copay/day	40% coinsurance	In Alabama, out-of-network benefits are only available for accidental injury and medical emergency Precertification is required In-network hospital copay of $1,500 / day is inclusive of all services administered in the hospital inpatient setting, e.g., maternity (normal delivery/healthy newborn), inpatient rehabilitation, inpatient dialysis, inpatient mental health/substance abuse, inpatient hospice, advanced radiology, standard radiology, and organ transplants. Separate copay will apply if newborn is admitted to NICU.
	Physician/surgeon fees	No Charge	No Charge	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	The lesser of the allowed amount or $40 copay/visit	40% coinsurance	Psychiatrist visits, psychologist visits, and intensive outpatient services/partial hospitalization for mental health disorders are subject to the $40 in-network copay. Inpatient hospitalization for mental health / substance abuse subject to the $1,500 / day in-network copay. Benefits listed are physician services; additional benefits are available; precertification is required for intensive outpatient, partial hospitalization and inpatient hospitalization
	Inpatient services	See information on hospital stays above.	40% coinsurance	
If you are pregnant	Office visits	No Charge	40% coinsurance	Cost sharing does not apply for preventive services. Maternity - newborn admitted separately from mother (e.g., to the NICU) will require a separate per day copay
	Childbirth/delivery professional services	No Charge	40% coinsurance	
	Childbirth/delivery facility services	The lesser of the allowed amount or $1,500 copay/day	40% coinsurance	

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 help recovering or have other special health needs	Home health care	The lesser of the allowed amount or $40 copay/visit	40% coinsurance	Precertification is required; copay applies per provider per day; benefits are also available for home infusion services
	Rehabilitation services	The lesser of the allowed amount or $60 copay/visit	40% coinsurance	Benefits listed are for Rehabilitation & Habilitation services; each service has a combined maximum of 60 visits for occupational, physical and speech therapy per year; respiratory therapy has a limit of 60 visits per year; includes facility and physician services; members with an autistic diagnosis are allowed unlimited visits; includes facility and physician services for cardiac rehabilitation
	Habilitation services	The lesser of the allowed amount or $60 copay/visit	40% coinsurance	
	Skilled nursing care	The lesser of the allowed amount or $1,500 copay/day	40% coinsurance	Precertification is required
	Durable medical equipment	The lesser of the allowed amount or $150 copay/device	40% coinsurance	Rental up to the purchase price; one copay applies each month for each rental; one copay applies for resupplies or purchase per item
	Hospice services	No Charge	40% coinsurance	In Alabama, not covered; precertification is required
If your child needs dental or eye care	Children's eye exam	No Charge	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	Not Covered	Please visit AlabamaBlue.com/preventiveservices

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
- Cosmetic surgery
- Dental care (Adult)
- Glasses, child
- Long-term care
- Private-duty nursing
- Routine foot care
- Weight loss programs
- Routine eye care (Adult)

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

- Chiropractic care (limitations apply)
- Infertility treatment (Assisted reproduction technology not covered)
- Non-emergency care when traveling outside the U.S.
- Bariatric surgery
- Hearing aids (limitations 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: 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.

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 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.

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

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	$0
Specialist copay/coinsurance	$120/0%
Hospital (facility) copay/coinsurance	$1,500/0%
Other copay/coinsurance	$1,000/0%

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	$0
Copayments	$3,720
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$3,780

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

The plan's overall deductible	$0
Specialist copay/coinsurance	$120/0%
Hospital (facility) copay/coinsurance	$1,500/0%
Other copay/coinsurance	$1,000/0%

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	$0
Copayments	$1,660
Coinsurance	$0
What isn't covered	
Limits or exclusions	$40
The total Joe would pay is	$1,700

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

The plan's overall deductible	$0
Specialist copay/coinsurance	$120/0%
Hospital (facility) copay/coinsurance	$1,500/0%
Other copay/coinsurance	$1,000/0%

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

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$2,010
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$2,010

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**.