

**Southern Energy Homes-Simple Plus 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.bcbosal.org/sbcglossary/](#) or call 1-800-292-8868 to request a copy.

Important Questions	Answers	Why This Matters:
<a href="#">What is the overall deductible?</a>	For in-network: \$0 For out of network \$3,000 individual/\$6,000 family out-of-network.	See the Common Medical Events chart below for your costs for services this plan covers.
<a href="#">Are there services covered before you meet your deductible?</a>	Yes. In-network services are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<a href="#">Are there other deductibles for specific services?</a>	No.	You don't have to meet <a href="#">deductible</a> for specific services.
<a href="#">What is the out-of-pocket limit for this plan?</a>	For in-network \$4,000 individual/\$8,000 family. For out-of-network \$8,000 individual/\$16,000 family.	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limit</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
<a href="#">What is not included in the out-of-pocket limit?</a>	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 <a href="#">out-of-pocket limit</a> .
<a href="#">Will you pay less if you use a network provider?</a>	Yes. See <a href="#">AlabamaBlue.com</a> or call 1-800-810-BLUE for a list of network providers.	This <a href="#">plan</a> uses a <a href="#">provider</a> network. You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan</a> 's network. You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
<a href="#">Do you need a referral to see a specialist?</a>	No.	You can see the <a href="#">specialist</a> 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 <u><a href="#">provider's</a></u> office or clinic	Primary care visit to treat an injury or illness	The lesser of the allowed amount or \$25 <u><a href="#">copay</a></u> /visit	40% <u><a href="#">coinsurance</a></u>	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.
	<u><a href="#">Specialist</a></u> visit	The lesser of the allowed amount or \$60 <u><a href="#">copay</a></u> /visit	40% <u><a href="#">coinsurance</a></u>	Psychiatrist visits, psychologist visits, and intensive outpatient services/partial hospitalization for mental health disorders are subject to the \$25 in-network copay.
	<u><a href="#">Preventive care/screening/</a></u> Immunization/office services	No Charge	Not Covered	Chemotherapy, Radiation, Dialysis and IV Therapy performed in an office setting are subject to a \$150 copay.  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	<u><a href="#">Diagnostic test</a></u> (for example-standard radiology like an x-ray, ultrasound, etc.)	The lesser of the allowed amount or \$60 <u><a href="#">copay</a></u> /visit	40% <u><a href="#">coinsurance</a></u>	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 (\$60 in-network copay does not apply).  \$60 in-network copay is inclusive of both facility and physician charges.  Lab and pathology are provided at no charge (\$60 in-network diagnostic test copay does not apply).
	Advanced Imaging (for example-CT/PET scans, MRIs, etc.)	The lesser of the allowed amount or \$200 <u><a href="#">copay</a></u> /visit	40% <u><a href="#">coinsurance</a></u>	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 (\$200 in-network copay does not apply).  Precertification required for advanced imaging  \$200 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)	
<b>If you need drugs to treat your illness or condition</b>  More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.express-scripts.com">www.express-scripts.com</a>	Tier 1 Drugs	The lesser of the allowed amount or \$10 <a href="#">copay</a> (retail/34-day supply) The lesser of the allowed amount or \$25 <a href="#">copay</a> (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 \$60 <a href="#">copay</a> (retail/34-day supply) The lesser of the allowed amount or \$150 <a href="#">copay</a> (mail order/90-day supply)	Not Covered	
	Tier 3 Drugs	The lesser of the allowed amount or \$150 <a href="#">copay</a> retail/34-day supply) The lesser of the allowed amount or \$375 <a href="#">copay</a> (mail order/90-day supply)	Not Covered	
	Tier 4 Drugs	The lesser of the allowed amount or \$150 <a href="#">copay</a> (retail/34-day supply) The lesser of the allowed amount or \$375 <a href="#">copay</a> (mail order/90-day supply)	Not Covered	

\* For more information about limitations and exceptions, see the plan or policy document at [AlabamaBlue.com](http://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)	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 \$350 <a href="#">copay</a>	40% <a href="#">coinsurance</a>	<p>Facility fee covers facility and physician services associated with an outpatient surgery, but other services (e.g., advanced imaging) would require additional copays.</p> <p>Example services included in this outpatient surgery category: interventional radiology, therapeutic radiology, diagnostic colonoscopies and bariatric surgery performed in an outpatient setting.</p>
	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 \$500 <a href="#">copay</a> /visit Medical Emergency: The lesser of the allowed amount or \$500 <a href="#">copay</a> /visit	Accident: The lesser of the allowed amount or \$500 <a href="#">copay</a> /visit No overall deductible Medical Emergency: The lesser of the allowed amount or \$500 <a href="#">copay</a> /visit No overall deductible	<p>Includes 23 hour observation; copay waived if admitted; includes all services in the emergency room</p>
	Emergency medical transportation	The lesser of the allowed amount or \$350 <a href="#">copay</a> /per trip	The lesser of the allowed amount or \$350 <a href="#">copay</a> /visit No overall deductible	Includes ground and air ambulance
	Urgent care	The lesser of the allowed amount or \$50 <a href="#">copay</a> /visit	40% <a href="#">coinsurance</a>	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)	
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	The lesser of the allowed amount or \$750 <a href="#">copay</a> /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 \$750 / 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
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	The lesser of the allowed amount or \$25 <a href="#">copay</a> /visit	40% <a href="#">coinsurance</a>	Psychiatrist visits, psychologist visits, and intensive outpatient services/partial hospitalization for mental health disorders are subject to the \$25 in-network copay.
	Inpatient services	See information on hospital stays above.	40% <a href="#">coinsurance</a>	Inpatient hospitalization for mental health / substance abuse subject to the \$750 / day in-network copay.  Benefits listed are physician services; additional benefits are available; precertification is required for intensive outpatient, partial hospitalization and inpatient hospitalization
<b>If you are pregnant</b>	Office visits	No Charge	40% <a href="#">coinsurance</a>	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% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	The lesser of the allowed amount or \$750 copay/day	40% coinsurance	

\* For more information about limitations and exceptions, see the plan or policy document at [AlabamaBlue.com](http://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)	Out-of-Network Provider (You will pay the most)	
<b>If you need help recovering or have other special health needs</b>	<a href="#"><u>Home health care</u></a>	The lesser of the allowed amount or \$25 <a href="#"><u>copay</u></a> /visit	40% <a href="#"><u>coinsurance</u></a>	Precertification is required; copay applies per provider per day; benefits are also available for home infusion services
	<a href="#"><u>Rehabilitation services</u></a>	The lesser of the allowed amount or \$40 <a href="#"><u>copay</u></a> /visit	40% <a href="#"><u>coinsurance</u></a>	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
	<a href="#"><u>Habilitation services</u></a>	The lesser of the allowed amount or \$40 <a href="#"><u>copay</u></a> /visit	40% <a href="#"><u>coinsurance</u></a>	
	<a href="#"><u>Skilled nursing care</u></a>	The lesser of the allowed amount or \$750 <a href="#"><u>copay</u></a> /day	40% <a href="#"><u>coinsurance</u></a>	Precertification is required
	<a href="#"><u>Durable medical equipment</u></a>	The lesser of the allowed amount or \$100 <a href="#"><u>copay</u></a> /device	40% <a href="#"><u>coinsurance</u></a>	Rental up to the purchase price; one copay applies each month for each rental; one copay applies for resupplies or purchase per item
	<a href="#"><u>Hospice services</u></a>	No Charge	40% <a href="#"><u>coinsurance</u></a>	In Alabama, not covered; precertification is required
<b>If your child needs dental or eye care</b>	Children's eye exam	No Charge	Not Covered	Please visit <a href="#">AlabamaBlue.com/preventiveservices</a>
	Children's glasses	Not Covered	Not Covered	Not covered; member pays 100%
	Children's dental check-up	No Charge	Not Covered	Please visit <a href="#">AlabamaBlue.com/preventiveservices</a>

\* 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.)

- 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
- Hearings 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](http://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](http://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](http://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.*

## 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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
<a href="#">Specialist copay/coinsurance</a>	\$60/0%
Hospital (facility) <a href="#">copay/coinsurance</a>	\$750/0%
<a href="#">Other copay/coinsurance</a>	\$500/0%

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	\$2,130
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$2,190</b>

### Managing Joe's type 2 Diabetes

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

The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
<a href="#">Specialist copay/coinsurance</a>	\$60/0%
Hospital (facility) <a href="#">copay/coinsurance</a>	\$750/0%
<a href="#">Other copay/coinsurance</a>	\$500/0%

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	\$1,090
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$40
<b>The total Joe would pay is</b>	<b>\$1,130</b>

### Mia's Simple Fracture

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

The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
<a href="#">Specialist copay/coinsurance</a>	\$60/0%
Hospital (facility) <a href="#">copay/coinsurance</a>	\$750/0%
<a href="#">Other copay/coinsurance</a>	\$500/0%

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	\$1,450
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,450</b>

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](#).