Tiffin Motor Homes, Inc.

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 x-xxx-xxx-xxxx or visit us at insertwebsite.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?	In-network Alabama: $350 individual/$1,050 family In-network outside Alabama and Out-of-network: $700 individual/$2,100 family.	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 https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. $600 per admission in-network. $1,200 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?	For in-network $2,500 individual/$5,000 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, cost sharing for most out-of-network benefits, pre-certification penalties and pharmacy copays.	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	$40 copay/visit No overall deductible	35% coinsurance	None
	Specialist visit	$60 copay/visit No overall deductible	35% coinsurance	
	Preventive care/screening/ immunization	No Charge No overall deductible	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 No overall deductible	35% coinsurance	Benefits listed are physician services; facility benefits are also available; precertification may be required
	Imaging (CT/PET scans, MRIs)	No Charge No overall deductible	35% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at [insertwebsite]	Tier 1 Drugs	Not Covered	Not Covered	None
	Tier 2 Drugs	Not Covered	Not Covered	
	Tier 3 Drugs	Not Covered	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$600 copay No overall deductible	35% coinsurance	None
	Physician/surgeon fees	No Charge No overall deductible	35% coinsurance	None
If you need immediate medical attention	Emergency room care	Accident: $175 copay/visit No overall deductible Medical Emergency: $175 copay/visit No overall deductible	Accident: $175 copay/visit No overall deductible Medical Emergency: $175 copay/visit No overall deductible	Physician charges will apply
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	$60 copay/visit No overall deductible	35% coinsurance	None

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)	$600 per admission deductible & $175 copay/day days 2-11 No overall deductible	$1,200 per admission deductible & 35% coinsurance No overall deductible	In Alabama, out-of-network benefits are only available for accidental injury; precertification is required
	Physician/surgeon fees	No Charge No overall deductible	35% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not Covered	Not Covered	None
	Inpatient services	Not Covered	Not Covered	
If you are pregnant	Office visits	No Charge No overall deductible	35% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound)
	Childbirth/delivery professional services	No Charge No overall deductible	35% coinsurance	
	Childbirth/delivery facility services	$600 per admission deductible & $175 copay/day days 2-11 No overall deductible	$1,200 per admission deductible & 35% coinsurance No overall deductible	
If you need help recovering or have other special health needs	Home health care	No Charge No overall deductible	35% coinsurance	Precertification may be required; benefits are also available for home infusion services
	Rehabilitation services	20% coinsurance	35% coinsurance	Benefits listed are for Rehabilitation and Habilitation services for occupational and physical therapy; occupational therapy is limited to certain services related to hand and lymphedema; speech therapy is not covered;
	Habilitation services	20% coinsurance	35% coinsurance	
	Skilled nursing care	Not Covered	Not Covered	Not covered; member pays 100%
	Durable medical equipment	20% coinsurance	35% coinsurance	None
	Hospice services	No Charge No overall deductible	35% coinsurance	Precertification may be required
If your child needs dental or eye care	Children's eye exam	No Charge No overall deductible	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 No overall deductible	Not Covered	Please visit AlabamaBlue.com/preventiveservices

* For more information about limitations and exceptions, see the plan or policy document at insertwebsite.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	• Hearing aids	• Routine eye care (Adult)
• Cosmetic surgery	• Long-term care	• Routine foot care
• Dental care (Adult)	• Prescription Drugs	• Skilled nursing care
• Glasses, child	• Private-duty nursing	• Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)	
• Bariatric surgery (only for morbid obesity in limited circumstances)	• Infertility treatment (Assisted Reproductive Technology not covered)
• Chiropractic care (limited to 30 visits per member per calendar year)	• 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: 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/No**

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 insertwebsite.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	$350
Specialist copay/coinsurance	$60/0%
Hospital (facility) copay/coinsurance	$175/0%
Other copay/coinsurance	$175/20%

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*	$0
Copayments	$780
Coinsurance	$0
What isn't covered	
Limits or exclusions	$70
The total Peg would pay is	$850

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

The plan's overall deductible	$350
Specialist copay/coinsurance	$60/0%
Hospital (facility) copay/coinsurance	$175/0%
Other copay/coinsurance	$175/20%

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*	$170
Copayments	$250
Coinsurance	$0
What isn't covered	
Limits or exclusions	$4,000
The total Joe would pay is	$4,450

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

The plan's overall deductible	$350
Specialist copay/coinsurance	$60/0%
Hospital (facility) copay/coinsurance	$175/0%
Other copay/coinsurance	$1745/20%

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*	$350
Copayments	$300
Coinsurance	$240
What isn't covered	
Limits or exclusions	$10
The total Mia would pay is	$900

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: insertwebsite.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.

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