Auburn University

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 1-800-633-8052 or visit us at auburn.edu. 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?	$500 individual; 3-member family maximum	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?	No.	You don't have to meet deductible for specific services.
What is the out–of–pocket limit for this plan?	For in-network $8,700 individual/$17,400 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 and pre-certification penalties and specialty drug coupon program payments.	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	$30 copay/visit No overall deductible	20% coinsurance	None
	Specialist visit	$40 copay/visit No overall deductible	20% 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	20% coinsurance	Benefits listed are physician services; facility benefits are also available; precertification may be required; medical specialty drug IV therapy in an outpatient setting and office visit setting, 70% subject to the calendar year deductible in and out of network
	Imaging (CT/PET scans, MRIs)	No Charge No overall deductible	20% coinsurance	
	Tier 1 Drugs	$15 copay (retail) No overall deductible	$30 copay (retail) No overall deductible	Prior authorization required for specific drugs; member pays the copay plus the difference between the allowance and the actual billed charge for out-of-network outside Alabama; In Alabama, out-of-network not covered; Auburn University will waive $15 copay for all Tier 1 medications and Tier 2 medications will have a $10 copay when filled at Auburn University Pharmaceutical Care Center (AUPCC) when
	Tier 2 Drugs	$25 copay (retail) No overall deductible	$40 copay (retail) No overall deductible	
	Tier 3 Drugs	$55 copay (retail) No overall deductible	$70 copay (retail) No overall deductible	
	Tier 4 Drugs	$85 copay (retail) No overall deductible	$100 copay (retail) No overall deductible	

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 AlabamaBlue.com/pharmacy	Tier 5 Drugs (preferred specialty)	25% coinsurance (retail) No overall deductible	25% coinsurance (retail) No overall deductible	employee enrolls and meets requirements in TigerMeds program; generic equivalents mandatory when available; please visit AlabamaBlue.com and go to "pharmacy" for more prescription drug information; specialty drugs up to a maximum of $800. Drugs in Specialty Drug Coupon Program, subject to greater of applicable Tier copay or the available payment under the specialty drug coupon program; go to Alabamablue.com/specialtycouponprogram druglist for a list of these specialty drugs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$300 copay Subject to Calendar Year Deductible	$300 copay & 20% coinsurance Subject to Calendar Year Deductible	In Alabama, out-of-network not covered
	Physician/surgeon fees	No Charge No overall deductible	20% coinsurance	None
If you need immediate medical attention	Emergency room care	Accident: $300 copay/visit Medical Emergency: $300copay/visit, Subject to Calendar Year Deductible	Accident: $300 copay/visit Medical Emergency: $300 copay/visit Subject to In Network Calendar Year Deductible	Physician charges will apply.
	Emergency medical transportation	30% coinsurance Subject to Calendar Year Deductible	30% coinsurance Subject to In Network Calendar Year Deductible	Subject to in-network overall deductible
	Urgent care	$30 copay/visit No overall deductible	20% coinsurance	None

If you have a hospital stay	Facility fee (e.g., hospital room)	$300 per admission copay Subject to Calendar Year Deductible	$300 per admission copay& 20% coinsurance Subject to Calendar Year Deductible	In Alabama, out-of-network not covered; precertification is required for coverage; per admission copay waived for maternity admission if the covered member/spouse enrolls in Baby Yourself during the first 16 weeks of pregnancy.
	Physician/surgeon fees	No Charge No overall deductible	20% 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 need mental health, behavioral health, or substance abuse services	Outpatient Office Visits	$30 Copay per visit/session/group therapy session	20% Of the Allowed Amount and All Billed Charges Not Covered by The *Plan*	Up To 30 Visits/Sessions/Group Therapy Sessions (Or Any Combination Thereof) Total Each Calendar Year, Combined In-Network and Out-Of-Network, Combined Mental Health, Substance Abuse, and Eating Disorder Programs
	Psychological/Neuropsychological Testing	$30 Copay Per Hour of Testing	20% Of the Allowed Amount and All Billed Charges Not Covered by The *Plan*	Precertification Required. Call Uprise Health (formerly American Behavioral) at 800-677-4544 Limited to Five (5) Hours of Psychological/ Neuropsychological Testing Per Member Per Calendar Year Combined In- and Out-Of-Network
	Applied Behavior Analysis for Treatment of Autism Spectrum Disorder	• Ages 0-9: Up to $20,000 Per Child Per Calendar Year • Ages 10-13: Up to $15,000 Per Child Per Calendar Year • Ages 14-18: Up to $10,000 Per Child Per Calendar Year	No Out-of-Network Benefit	Precertification Required. Call Uprise Health (formerly American Behavioral) at 800-677-4544
	Inpatient Services Including: • Acute Inpatient Hospitalization • Inpatient Electroconvulsive Therapy (ECT) • PHP Two (2) PHP days equal one (1) inpatient day • IOP Two (2) IOP days equal one (1) inpatient day	$300 Per Admission Deductible Subject to Calendar Year Deductible	20% Of Allowed Amount Subject to Calendar Year Deductible and All Other Billed Charges Not Covered by The Plan	Inpatient Services Limited To 30 Days Total Per Calendar Year Combined In- Network and Out-Of-Network Pre-Admission Certification Required for All Inpatient Services. Call Uprise Health (formerly American Behavioral) at 800-677-4544

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 mental health, behavioral health, or substance abuse services-- ***Continued***	Substance Abuse Program Inpatient Services, Including: • Detoxification • Rehabilitation • PHP Two (2) PHP days equal one (1) inpatient day • IOP Two (2) IOP days equal one (1) inpatient day	$300 Per Admission Deductible Subject to Calendar Year Deductible	No Out-of-Network Benefit	Pre-Admission Certification Required Call Uprise Health (formerly American Behavioral) at 800-677-4544 Substance Abuse Treatment = Once Per Lifetime Per Insured Member Inpatient Hospital Services-- Up To 30 Days Total Per Lifetime Per Insured Member
	Substance Abuse Program Ambulatory Detoxification (Outpatient Office Visit)	$30 Copay Per Visit/Session/Group Therapy Session	20% Of Allowed Amount and All Other Billed Charges Not Covered by the *Plan*	Up To 30 Visits/Sessions/Group Therapy Sessions (Or Any Combination Thereof) Total Each Calendar Year, Combined In-Network and Out-of-Network, Combined Mental Health, Substance Abuse, and Eating Disorder Programs
	Eating Disorders Program Inpatient Services Including: • Inpatient Hospitalization • PHP Two (2) PHP days equal one (1) inpatient day • IOP Two (2) IOP days equal one (1) inpatient day	$300 Per Admission Deductible Subject to Calendar Year Deductible	No Out-of-Network Benefit	Pre-Admission Certification Required Call American Behavioral at 800-677-4544 Eating Disorders Treatment = Once Per Lifetime Per Insured Member Inpatient Hospital Services-- Up To 30 Days Total per lifetime per insured member
	Eating Disorders Program Outpatient Office Visits	$30 Copay Per Visit/Session/Group Therapy Session	20% Of Allowed Amount and all other billed charges not covered by the Plan	Up To 30 Visits/Sessions/Group Therapy Sessions (Or Any Combination Thereof) Total Each Calendar Year, Combined In-Network and Out-of-Network, Combined Mental Health, Substance Abuse, and Eating Disorder Programs

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 are pregnant	Office visits	No Charge No overall deductible	20% 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	20% coinsurance Subject to Calendar Year Deductible	
	Childbirth/delivery facility services	$300 per admission copay Subject to Calendar Year Deductible	$300 per admission copay & 20% coinsurance Subject to Calendar Year Deductible	
If you need help recovering or have other special health needs	Home health care	0% coinsurance Subject to Calendar Year Deductible	30% coinsurance Subject to Calendar Year Deductible	In Alabama, out-of-network not covered; precertification may be required; benefits for home infusion services, 70% subject to the calendar year deductible for in-network
	Rehabilitation services	30% coinsurance Subject to Calendar Year Deductible	30% coinsurance Subject to Calendar Year Deductible	Benefits listed are for Rehabilitation & Habilitation services; each service has a combined maximum of 30 visits for occupational, physical and speech therapy per year
	Habilitation services	30% coinsurance Subject to Calendar Year Deductible	30% coinsurance Subject to Calendar Year Deductible	
	Skilled nursing care	Not Covered	Not Covered	Not covered; member pays 100%
	Durable medical equipment	30% coinsurance Subject to Calendar Year Deductible	30% coinsurance Subject to Calendar Year Deductible	None
	Hospice services	0% coinsurance Subject to Calendar Year Deductible	30% coinsurance Subject to Calendar Year Deductible	In Alabama, out-of-network not covered; 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 auburn.edu

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/Adult
- Hearing aids
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- 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 morbid obesity in limited circumstances)
- Chiropractic care
- Infertility treatment (Assisted Reproductive Technology not covered)
- 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 Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323 x61565 or www.cciio.cms.gov. If coverage is insured, contact your State insurance regulator regarding your possible rights to continuation coverage under State Law. 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: Blue Cross and Blue Shield of Alabama at 1-800-633-8052.

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 auburn.edu

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	$500
Specialist copay/coinsurance	$40/0%
Hospital (facility) copay/coinsurance	$300/0%
Other copay/coinsurance	$300/30%

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	$500
Copayments	$310
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$870

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

The plan's overall deductible	$500
Specialist copay/coinsurance	$40/0%
Hospital (facility) copay/coinsurance	$300/0%
Other copay/coinsurance	$300/30%

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	$680
Coinsurance	$0
What isn't covered	
Limits or exclusions	$40
The total Joe would pay is	$890

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

The plan's overall deductible	$500
Specialist copay/coinsurance	$40/0%
Hospital (facility) copay/coinsurance	$300/0%
Other copay/coinsurance	$300/30%

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	$500
Copayments	$390
Coinsurance	$320
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,210

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

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: auburn.edu