BlueCross BlueShield of Alabama

## : Auburn University SHP/Montgomery SAP

**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 1-866-346-4585 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 1-866-346-4585 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | From 07/1/2023 to 08/15/2024:<br>$250 individual in-network.<br>$500 individual out-of-network. | 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 $7,150 individual/$14,300 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 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 | $25 copay<br>No overall deductible | 40% coinsurance | In-network benefits listed are Auburn University Medical Center (AUMC)/Warhawk Health office visits; any other medical service available and rendered at AUMC/Warhawk Health Services and services for certain allergy injections, B12 injections and certain therapeutic services will be covered at no charge; to receive treatment from a provider other than AUMC/Warhawk Health Services for outpatient treatment, a referral must be obtained for members age 18 and over; benefits for PPO Providers 20% coinsurance, subject to overall deductible; in Alabama, out-of-network coinsurance is 50% |
| | Specialist visit | 20% coinsurance | 40% coinsurance | |
| | Preventive care/screening/ immunization | No Charge<br>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) | 20% coinsurance | 40% coinsurance | Benefits listed are physician services; in Alabama, out-of-network coinsurance is 50%; facility benefits are also available; precertification may be required |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance | 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 drugs to treat your illness or condition**<br><br>More information about **prescription drug coverage** is available at AlabamaBlue.com/pharmacy | Tier 1 Drugs | $10 copay (AUMC)<br>$20 copay (retail)<br>$50 copay (mail order)<br>No overall deductible | Not Covered | Warhawk Health Services does have an on-site pharmacy; prior authorization required for specific drugs; covered insulin products may have lower patient responsibility; select generic specialty and biosimilar drugs on the Select Generic Specialty and Biosimilar Drug List will have lower member cost share |
| | Tier 2 Drugs | $10 copay (AUMC)<br>$20 copay (retail)<br>$50 copay (mail order)<br>No overall deductible | Not Covered | |
| | Tier 3 Drugs | $45 copay (AUMC)<br>$60 copay (retail)<br>$150 copay (mail order)<br>No overall deductible | Not Covered | |
| | Tier 4 Drugs | $75 copay (AUMC)<br>$90 copay (retail)<br>$225 copay (mail order)<br>No overall deductible | Not Covered | |
| | Tier 5 Drugs (preferred specialty) | $45 copay (AUMC)<br>$60 copay (retail)<br>No overall deductible | Not Covered | |
| | Tier 6 Drugs (non-preferred specialty) | $75 copay (AUMC)<br>$90 copay (retail)<br>No overall deductible | Not Covered | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | 40% coinsurance | In Alabama, out-of-network not covered |
| | Physician/surgeon fees | 20% coinsurance | 40% coinsurance | In Alabama, out-of-network coinsurance is 50% |
| **If you need immediate medical attention** | Emergency room care | Accident: $100 copay/visit and 20% coinsurance<br>Medical Emergency: $100 copay/visit and 20% coinsurance | Accident: $100 copay/visit and 20% coinsurance<br>Medical Emergency: $100 copay/visit and 20% coinsurance | Physician charges will apply; copay waived if admitted |
| | Emergency medical transportation | 20% coinsurance | 20% coinsurance | None |
| | Urgent care | 20% coinsurance | 40% coinsurance | In Alabama, out-of-network coinsurance is 50% |

* For more information about limitations and exceptions, see the plan or policy document at 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 a hospital stay** | Facility fee (e.g., hospital room) | $250 copay/visit and 20% coinsurance | $250 copay/visit and 20% coinsurance | In Alabama, out-of-network benefits are only available for accidental injury and medical emergency; precertification is required |
| | Physician/surgeon fees | 20% coinsurance | 40% coinsurance | In Alabama, out-of-network coinsurance is 50% |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $25 copay<br>No overall deductible | 40% coinsurance | In-network benefits listed are Auburn University Medical Center; to receive treatment from a provider other than AUMC for outpatient treatment, a referral must be obtained; benefits for PPO Providers 20% coinsurance, subject to overall deductible; in Alabama, out-of-network coinsurance is 50% additional benefits are available; may require higher patient responsibility; precertification is required for intensive outpatient, partial hospitalization and inpatient hospitalization |
| | Inpatient services | $250 copay/visit and 20% coinsurance | $250 copay/visit and 20% coinsurance | |
| **If you are pregnant** | Office visits | 20% coinsurance | 40% 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); in Alabama, out-of-network coinsurance is 50% for professional services |
| | Childbirth/delivery professional services | 20% coinsurance | 40% coinsurance | |
| | Childbirth/delivery facility services | $250 copay/visit and 20% coinsurance | $250 copay/visit and 20% 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 | 20% coinsurance | 40% coinsurance | In Alabama, out-of-network not covered; benefits are also available for home infusion services; precertification may be required |
| | Rehabilitation services | 20% coinsurance | 40% coinsurance | Benefits listed are for Rehabilitation & Habilitation services; each service has a combined maximum of 30 visits for occupational, physical and speech therapy per year; in Alabama, out-of-network coinsurance is 50%; children ages 0-18 with an autistic diagnosis are allowed unlimited visits for occupational, physical and speech therapy |
| | Habilitation services | 20% coinsurance | 40% coinsurance | |
| | Skilled nursing care | 20% coinsurance | 40% coinsurance | In Alabama, out-of-network coinsurance is 50%; precertification is required |
| | Durable medical equipment | 20% coinsurance | 40% coinsurance | In Alabama, out-of-network coinsurance is 50% |
| | Hospice services | 20% coinsurance | 40% coinsurance | In Alabama, out-of-network not covered; precertification may be required |
| **If your child needs dental or eye care** | Children's eye exam | $20 copay/visit<br>No overall deductible | Not Covered | Benefit listed is for pediatric eye exam; limitations apply; please visit AlabamaBlue.com/preventiveservices for mandated services covered at no charge; additional benefits are available; limitations apply |
| | Children's glasses | $40 copay/visit<br>No overall deductible | 50% coinsurance | Additional benefits available; limitations apply |
| | Children's dental check-up | 50% coinsurance | 50% coinsurance | Additional benefits available; limitations apply |

## 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.) | | |
|---|---|---|
| • Abortion (except when necessary to prevent serious health risk to the woman or as required by applicable laws)<br>• Acupuncture<br>• Bariatric surgery<br>• Cosmetic surgery | • Dental care (Adult)<br>• Hearing aids<br>• Long-term care<br>• Private-duty nursing | • Routine eye care (Adult)<br>• Routine foot care<br>• Weight loss programs |

| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.) | | |
|---|---|---|
| • 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 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 or your state insurance department.

**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 | $250 |
| Specialist copay/coinsurance | $25/0% |
| Hospital (facility) copay/coinsurance | $0/20% |
| Other copay/coinsurance | $100/20% |

**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 | $250 |
| Copayments | $260 |
| Coinsurance | $2410 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | $2,980 |

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

| | |
|---|---|
| The plan's overall deductible | $250 |
| Specialist copay/coinsurance | $25/0% |
| Hospital (facility) copay/coinsurance | $0/20% |
| Other copay/coinsurance | $100/20% |

**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 | $250 |
| Copayments | $660 |
| Coinsurance | $10 |
| *What isn't covered* | |
| Limits or exclusions | $40 |
| **The total Joe would pay is** | $960 |

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

| | |
|---|---|
| The plan's overall deductible | $250 |
| Specialist copay/coinsurance | $25/0% |
| Hospital (facility) copay/coinsurance | $0/20% |
| Other copay/coinsurance | $100/20% |

**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 | $250 |
| Copayments | $160 |
| Coinsurance | $420 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | $830 |

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.