BlueCross BlueShield of Alabama

: Tuskegee University - Student Health 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 1-800-292-8868 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?	From 08/01/2022 to 08/11/2023: $150 individual in-network. $750 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 $6,600 individual/$13,200 family. For out-of-network $13,200 individual/$26,400 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.	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	$15 copay/visit No overall deductible	$20 copay/visit	In Alabama, out-of-network coinsurance is 50%
	Specialist visit	$15 copay/visit No overall deductible	$20 copay/visit	
	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)	10% coinsurance	30% 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)	10% coinsurance	30% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at AlabamaBlue.com/pharmacy	Tier 1 Drugs	$5 copay (retail) $12.50 copay (mail order) No overall deductible	Not Covered	Prior authorization required for specific drugs; Covered insulin products may have lower patient responsibility
	Tier 2 Drugs	$5 copay (retail) $12.50 copay (mail order) No overall deductible	Not Covered	
	Tier 3 Drugs	$25 copay (retail) $62.50 copay (mail order) No overall deductible	Not Covered	
	Tier 4 Drugs	$40 copay (retail) $100 copay (mail order) No overall deductible	Not Covered	
	Tier 5 Drugs (preferred specialty)	$80 copay (retail) No overall deductible	Not Covered	
	Tier 6 Drugs (non-preferred specialty)	$80 copay (retail) No overall deductible	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	In Alabama, out-of-network not covered
	Physician/surgeon fees	10% coinsurance	30% coinsurance	In Alabama, out-of-network coinsurance is 50%

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 immediate medical attention	Emergency room care	Accident: $200 copay/visit No overall deductible Medical Emergency: $200 copay/visit No overall deductible	Accident: $200 copay/visit No overall deductible Medical Emergency: $200 copay/visit No overall deductible	Copay may be waived if admitted to hospital
	Emergency medical transportation	No Charge No overall deductible	No Charge No overall deductible	None
	Urgent care	$15 copay/visit No overall deductible	$20 copay/visit	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	In Alabama, out-of-network benefits are only available for accidental injury and medical emergency; precertification is required
	Physician/surgeon fees	10% coinsurance	30% coinsurance	In Alabama, out-of-network coinsurance is 50%
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15 copay/visit No overall deductible	$20 copay/visit	Benefits listed are physician services; additional benefits are available; may require higher patient responsibility; in Alabama, out-of-network coinsurance is 50%; precertification is required for intensive outpatient, partial hospitalization and inpatient hospitalization
	Inpatient services	10% coinsurance	30% coinsurance	
If you are pregnant	Office visits	10% coinsurance	30% 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	10% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	30% 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	10% coinsurance	30% coinsurance	In Alabama, out-of-network not covered; benefits are also available for home infusion services; precertification may be required
	Rehabilitation services	10% coinsurance	30% 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	10% coinsurance	30% coinsurance	
	Skilled nursing care	10% coinsurance	30% coinsurance	None
	Durable medical equipment	10% coinsurance	30% coinsurance	In Alabama, out-of-network coinsurance is 50%
	Hospice services	10% coinsurance	30% 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 No overall deductible	50% coinsurance	Benefits listed are mandated preventive services; please visit AlabamaBlue.com/preventiveservices; additional benefits are available; limitations apply
	Children's glasses	$50 copay/visit No overall deductible	50% coinsurance	Additional benefits available; limitations apply
	Children's dental check-up	50% coinsurance	50% coinsurance	Benefits listed are mandated preventive services; please visit AlabamaBlue.com/preventiveservices; additional benefits are 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 a serious health risk to the woman or as required by applicable laws)
- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (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.)

- 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	$150
Specialist copay/coinsurance	$15/0%
Hospital (facility) copay/coinsurance	$0/10%
Other copay/coinsurance	$200/10%

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	$150
Copayments	$10
Coinsurance	$1240
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$1,460

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

The plan's overall deductible	$150
Specialist copay/coinsurance	$15/0%
Hospital (facility) copay/coinsurance	$0/10%
Other copay/coinsurance	$200/10%

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	$150
Copayments	$310
Coinsurance	$20
What isn't covered	
Limits or exclusions	$40
The total Joe would pay is	$520

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

The plan's overall deductible	$150
Specialist copay/coinsurance	$15/0%
Hospital (facility) copay/coinsurance	$0/10%
Other copay/coinsurance	$200/10%

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	$150
Copayments	$240
Coinsurance	$120
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$510

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.