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?	$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?	Yes. Student Health Center will provide a referral.	This plan will pay some of all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

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%; no charges for services provided at an in-network by Student Health Center
	Specialist visit	$15 copay/visit No overall deductible	30% coinsurance No overall deductible	
	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 you need 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; if you fill your prescriptions at the Student Health Center, the plan will pay 100% of the allowed amount, no copay or deductible
	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 Medical Emergency: $200 copay/visit	Physician charges will apply; copay will be waived if admitted to the 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	In Alabama, out-of-network coinsurance is 50%
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 to certain 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; 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	In Alabama, out-of-network not covered
	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	No Charge No overall deductible	Not Covered	Benefits listed are mandated preventive services; please visit AlabamaBlue.com/preventiveservices; additional benefits are available; limitations apply
	Children's glasses	$40 copay/visit No overall deductible	50% coinsurance	Additional benefits available; limitations apply; patient responsibility may vary
	Children's dental check-up	No Charge No overall deductible	Not Covered	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.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Routine eye care (Adult)
- Hearing aids
- Long-term care
- Private-duty nursing
- Routine foot care
- Weight loss programs

* For more information about limitations and exceptions, see the plan or policy document at AlabamaBlue.com.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Chiropractic care • Dental care (Adult) Benefits paid for one annual exam and cleaning up to $100 per Plan Year	• 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**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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	$15/10%

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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$150
Copayments	$20
Coinsurance	$1240
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$1,470

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	$15/10%

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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$140
Copayments	$370
Coinsurance	$0
What isn't covered	
Limits or exclusions	$420
The total Joe would pay is	$930

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	$15/10%

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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$150
Copayments	$50
Coinsurance	$60
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$260

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.

Language Access Services and Notice of Nondiscrimination:

Blue Cross and Blue Shield of Alabama complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. We do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Blue Cross and Blue Shield of Alabama:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages

If you need these services, contact our 1557 Compliance Coordinator. If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person or by mail, fax, or email at: Blue Cross and Blue Shield of Alabama, Compliance Office, 450 Riverchase Parkway East, Birmingham, Alabama 35244, Attn: 1557 Compliance Coordinator, 1-855-216-3144, 711 (TTY), 1-205-220-2984 (fax), 1557Grievance@bcbsal.org (email). If you need help filing a grievance, our 1557 Compliance Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Foreign Language Assistance

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-216-3144 (TTY: 711)

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-216-3144 (TTY: 711)번으로 전화해 주십시오.

Chinese: **注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電** 1-855-216-3144 (TTY: 711）。

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-216-3144 (TTY: 711).

Arabic: انتباه: إذا كنت تتحدث العربية، توجد خدمات مساعدة فيما يتعلق باللغة، بدون تكلفة، متاحة لك. اتصل ب1-855-216-3144 (الهاتف النصي: 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-216-3144 (TTY: 711).

French: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-216-3144 (ATS: 711).

French Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-855-216-3144 (TTY: 711).

Gujarati: ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હોય, તો ભાષા સહાયતા સેવા, તમારા માટે નિઃશુલ્ક ઉપલબ્ધ છે. 1-855-216-3144 પર કૉલ કરો (TTY: 711).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-216-3144 (TTY: 711).

Hindi: ध्यान दें: अगर आपकी भाषा हिंदी है, तो आपके लिए भाषा सहायता सेवाएँ निःशुल्क उपलब्ध हैं। 1-855-216-3144 (TTY: 711) पर कॉल करें।

Laotian: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-855-216-3144 (TTY: 711).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-216-3144 (телетайп: 711).

Portuguese: ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-855-216-3144 (TTY: 711).

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-855-216-3144 (TTY: 711).

Turkish: DİKKAT: Eğer Türkçe konuşuyor iseniz, dil yardımı hizmetlerinden ücretsiz olarak yararlanabilirsiniz. 1-855-216-3144 (TTY: 711) irtibat numaralarını arayın.

Italian: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-216-3144 (TTY: 711).

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-855-216-3144（TTY: 711）まで、お電話にてご連絡ください。

We cover what matters.

BlueCard® PPO Plan Benefits

Tuskegee University Student Health Plan

BlueCard® PPO

Effective August 05, 2020

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BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Benefit payments are based on the amount of the provider's charge that Blue Cross and/or Blue Shield plans recognize for payment of benefits. The allowed amount may vary depending upon the type provider and where services are received.		
SUMMARY OF COST SHARING PROVISIONS (Includes Mental Health Disorders and Substance Abuse)		
Plan Year Deductible August 05, 2020-August 11, 2021 The in-network and out-of-network Plan Year Deductibles are separate and do not apply to each other	$150 individual	$750 individual
Plan Year Out-of-Pocket Maximum August 05, 2020-August 11, 2021 The in-network and out-of-network Plan Year out-of-pocket maximums are separate and do not apply to each other	$6,600 individual; $13,200 family All deductibles, copays and coinsurance for in-network services and all deductibles, copays and coinsurance for out-of-network mental health disorders and substance abuse emergency services apply to the out-of-pocket maximum. After you reach your Plan Year Out-of-Pocket Maximum, applicable expenses for you will be covered at 100% of the allowed amount for remainder of plan year	$13,200 individual; $26,400 family Coinsurance for out-of-network services (excluding out-of-network mental health disorders and substance abuse emergency services and out-of-network occupational therapy, physical therapy, speech therapy and DME in Alabama) apply to the out-of-network out-of-pocket maximum After you reach your Plan Year Out-of-Pocket Maximum, applicable expenses for you will be covered at 100% of the allowed amount for remainder of plan year
INPATIENT HOSPITAL AND PHYSICIAN BENEFITS (Includes Mental Health Disorders and Substance Abuse)		
Precertification is required for inpatient admissions (except medical emergency services and maternity); notification within 48 hours for medical emergencies. Generally, if precertification is not obtained, no benefits are available. Call 1-800-248-2342 (toll-free) for precertification.		
Inpatient Hospital and Residential Treatment Facilities	Covered at 90% of the allowed amount, subject to plan year deductible	Covered at 70% of the allowed amount, subject to plan year deductible **Note:** In Alabama, available only for medical emergency services and accidental injury
Inpatient Physician Visits and Consultations	Covered at 90% of the allowed amount, subject to plan year deductible	Covered at 70% of the allowed amount, subject to plan year deductible **In Alabama,** covered at 50% of the allowed amount, subject to plan year deductible
OUTPATIENT HOSPITAL BENEFITS (Includes Mental Health Disorders and Substance Abuse)		
Precertification is required for some outpatient hospital benefits. Precertification is also required for provider-administered drugs; visit AlabamaBlue.com/ProviderAdministeredPrecertificationDrugList. If precertification is not obtained, no benefits are available.		
Outpatient Surgery (Including Ambulatory Surgical Centers)	Covered at 90% of the allowed amount, subject to plan year deductible	Covered at 70% of the allowed amount, subject to plan year deductible **In Alabama,** not covered

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Emergency Room (Medical Emergency) **Note: Copay will be waived if admitted to the hospital**	Covered at 100% of the allowed amount, after $200.00 hospital copay	Covered at 100% of the allowed amount, after $200.00 hospital copay and subject to plan year deductible **Mental Health Disorders and Substance Abuse Services** covered at 100% of the allowed amount, after $200.00 hospital copay
Emergency Room (Accident) **Note:** If you have a medical emergency as defined by the plan after 72 hours of an accident, refer to **Emergency Room (Medical Emergency)** above. **Note: Copay will be waived if admitted to the hospital**	Covered at 100% of the allowed amount, after $200.00 hospital copay	Covered at 100% of the allowed amount, after $200.00 hospital copay and subject to plan year deductible for services rendered within 72 hours; covered at 70% of the allowed amount, subject to the plan year deductible when services are rendered after 72 hours of the accident and not a medical emergency as defined by the plan
Emergency Room (Physician)	Covered at 90% of the allowed amount, subject to plan year deductible	Covered at 90% of the allowed amount, subject to plan year deductible **Mental Health Disorders and Substance Abuse Services** covered at 90% of the allowed amount, subject to in-network plan year deductible
Chemotherapy, Dialysis, IV Therapy, Outpatient Diagnostic Lab, Pathology, Radiation Therapy & X-ray	Covered at 90% of the allowed amount, subject to plan year deductible	Covered at 70% of the allowed amount, subject to plan year deductible **In Alabama,** not covered
Intensive Outpatient Services and Partial Hospitalization for Mental Health Disorders and Substance Abuse Services	Covered at 90% of the allowed amount, subject to plan year deductible	Covered at 70% of the allowed amount, subject to plan year deductible **In Alabama,** not covered
PHYSICIAN BENEFITS **(Includes Mental Health Disorders and Substance Abuse)**		
Precertification is required for some physician benefits. Precertification is also required for provider-administered drugs; visit AlabamaBlue.com/ProviderAdministeredPrecertificationDrugList. **If precertification is not obtained, no benefits are available.**		
Office Visits & Consultations	Covered at 100% of the allowed amount, after $15.00 physician copay	Covered at 100% of the allowed amount, after $20.00 physician copay and subject to plan year deductible **In Alabama,** covered at 50% of the allowed amount, subject to plan year deductible

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Student Health Center Note: The student must use the services of the Health Center first where outpatient treatment will be administered or referral issued. Expenses incurred for medical treatment rendered outside of the Student Health Center for which no prior approval or referral is obtained are excluded from coverage. A referral issued by the SHC must accompany the claim when submitted. Only one referral is required for each injury or Sickness per Policy Year. Referral for outside care is not necessary only under the following conditions: • Medical Emergency • SHC is closed • Service is rendered at another facility during break or vacation periods • Medical care received when the student is more than 30 miles from campus • Medical care obtained when student is no longer able to use the SHC due to a change in student status • Maternity, obstetrical and gynecological care • Mental illness and Substance Use Disorder treatment • Dental Services do not require a referral from the Student Health Clinic Dependents are not eligible	Covered at 100% of the allowed amount, no copay or deductible	Not covered
Second Surgical Opinions	Covered at 100% of the allowed amount, after $15.00 physician copay	Covered at 70% of the allowed amount, subject to plan year deductible **In Alabama,** covered at 50% of the allowed amount, subject to plan year deductible
Surgery & Anesthesia	Covered at 90% of the allowed amount, subject to plan year deductible	Covered at 70% of the allowed amount, subject to plan year deductible **In Alabama,** covered at 50% of the allowed amount, subject to plan year deductible
Maternity Care	Covered at 90% of the allowed amount, subject to plan year deductible	Covered at 70% of the allowed amount, subject to plan year deductible **In Alabama,** covered at 50% of the allowed amount, subject to plan year deductible
Chemotherapy, Diagnostic Lab, Dialysis, IV Therapy, Pathology, Radiation Therapy & X-ray	Covered at 90% of the allowed amount, subject to plan year deductible	Covered at 70% of the allowed amount, subject to plan year deductible **In Alabama,** covered at 50% of the allowed amount, subject to plan year deductible

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Applied Behavioral Analysis (ABA) Therapy Limited to ages 0-18 for autism spectrum disorders	Covered at 90% of the allowed amount, subject to plan year deductible	Covered at 70% of the allowed amount, subject to plan year deductible
PREVENTIVE CARE BENEFITS		
Routine Immunizations and Preventive Services • See **AlabamaBlue.com/PreventiveServices** and **AlabamaBlue.com/StandardACAPreventiveDrugList** for listing of specific drugs, immunizations and preventive services or call our Customer Service Department for a printed copy • Certain immunizations may also be obtained through the Pharmacy Vaccine Network. See **AlabamaBlue.com/VaccineNetworkDrugList** for more information	Covered at 100% of the allowed amount, no copay or deductible	Not Covered
Note: In some cases, office visit copays or facility copays may apply. Blue Cross and Blue Shield of Alabama will process these claims as required by Section 1557 of the Affordable Care Act.		
PRESCRIPTION DRUG BENEFITS **(Includes Mental Health Disorders and Substance Abuse)**		
Precertification is required for some drugs; if precertification is not obtained, no benefits are available.		
If you fill your prescriptions at the Student Health Center, the plan will pay 100% of the allowed amount, no deductible or copayment.		
Retail Prescription Prepaid Benefits The retail pharmacy network for the plan is the **Prime Participating Network** • Locate a **Prime Participating** Network pharmacy at **AlabamaBlue.com/PrimeParticipatingPharmacyLocator** Maintenance drugs - up to 90-day supply may be purchased but copay applies for each 30-day supply • View the maintenance drug list that applies to the plan at **AlabamaBlue.com/MaintenanceDrugList** Prescription drugs (other than maintenance drugs) - up to a 30-day supply • Some copays combined for diabetic supplies • View the 2020 **Source+Rx 1.0** drug list that applies to the plan at **AlabamaBlue.com/2020SourcePlusRx1DrugList** The only in-network pharmacy for some Tier 5 and 6 (specialty) drugs is the **Pharmacy Select Network** • Tier 5 and 6 (specialty) drugs can be dispensed for up to a 30-day supply • View the Specialty Drug List at **AlabamaBlue.com/SelfAdministeredSpecialtyDrugList** Some immunizations may be received from an in-network pharmacy that participates in the Pharmacy Vaccine Network. A list of the eligible vaccines these pharmacies may provide can be found at: **AlabamaBlue.com/VaccineNetworkDrugList**	Covered at 100% of the allowed amount, subject to the following copays for a 30-day supply for each prescription: **Tier 1 Drugs:** $5 copay per prescription **Tier 2 Drugs:** $5 copay per prescription **Tier 3 Drugs:** $25 copay per prescription **Tier 4 Drugs:** $40 copay per prescription **Tier 5 (Preferred specialty) Drugs:** $80 copay per prescription **Tier 6 (Non-Preferred specialty) Drugs:** $80 copay per prescription	Not Covered

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Mail Order Pharmacy Benefits • Up to a 90-day supply with one copay • Mail Order Drugs are available through **Home Delivery Network** (Enroll online at **AlabamaBlue.com/ HomeDeliveryNetwork** or call 1-800-391-1886) Only maintenance drugs can be purchased through this mail order pharmacy service • View the maintenance drug list that applies to the plan at **AlabamaBlue.com/ MaintenanceDrugList** • View the 2020 **Source+Rx1.0** drug list that applies to the plan at **AlabamaBlue.com/2020SourcePlusRx1 DrugList** **Note:** If you have less than a 90-day supply, you will pay the same copay as a 90-day supply when using this mail order program	Covered at 100% of the allowed amount, subject to the following copays: **Tier 1 Drugs:** $12.50 copay per prescription **Tier 2 Drugs:** $12.50 copay per prescription **Tier 3 Drugs:** $62.50 copay per prescription **Tier 4 Drugs:** $100 copay per prescription **Tier 5 (Preferred specialty) Drugs:** Not covered **Tier 6 (Non-Preferred specialty) Drugs:** Not covered	Not Covered
VISION BENEFITS		
Pediatric Routine Vision Examination Limited to one per member per plan year for routine vision exam or refraction only in lieu of a complete exam	Covered at 100% of the allowed amount, after $20.00 copay	Covered at 50% of the allowed amount, subject to plan year deductible
Pediatric Eyeglass Lenses Limited to one per member per plan year **Note: Member can select either frames or contact lenses**	Covered at 100% of the allowed amount, after $40.00 copay	Covered at 50% of the allowed amount, subject to plan year deductible
Lens Extras	Covered at 100% of the allowed amount, no copay or deductible	Covered at 100% of the allowed amount, subject to plan year deductible
Pediatric Eyeglass Frames Limited to one pair of prescription glasses per member per plan year with a retail cost up to $130. **Note: Member can select either frames or contact lenses**	Covered at 100% of the allowed amount, no copay or deductible	Covered at 50% of the allowed amount, subject to plan year deductible
Pediatric Eyeglass Frames Limited to one pair of prescription glasses per member per plan year with a retail cost up to $130-$160. **Note: Member can select either frames or contact lenses**	Covered at 100% of the allowed amount, after $15.00 copay	Covered at 50% of the allowed amount, subject to plan year deductible
Pediatric Eyeglass Frames Limited to one pair of prescription glasses per member per plan year with a retail cost up to $160-$200. **Note: Member can select either frames or contact lenses**	Covered at 100% of the allowed amount, after $30.00 copay	Covered at 50% of the allowed amount, subject to plan year deductible

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Pediatric Eyeglass Frames Limited to one pair of prescription glasses per member per plan year with a retail cost up to $200-$250. **Note: Member can select either frames or contact lenses**	Covered at 100% of the allowed amount, after $50.00 copay	Covered at 50% of the allowed amount, subject to plan year deductible
Pediatric Eyeglass Frames Limited to one pair of prescription glasses per member per plan year with a retail cost greater than $250. **Note: Member can select either frames or contact lenses**	Covered at 60% of the allowed amount, subject to plan year deductible	Covered at 50% of the allowed amount, subject to plan year deductible
Pediatric Contact Lenses Fittings & Evaluation Limited to one per plan year	Covered at 100% of the allowed amount, no copay or deductible	Covered at 100% of the allowed amount, no copay or deductible
Pediatric Contact Lenses Limited to one 12-month supply per plan year **Note: Member can select either frames or contact lenses**	Covered at 100% of the allowed amount, after $40.00 copay	Covered at 50% of the allowed amount, subject to plan year deductible
BENEFITS FOR OTHER COVERED SERVICES (Includes Mental Health Disorders and Substance Abuse)		
Precertification is required for some other covered services; please see your benefit booklet. If precertification is not obtained, no benefits are available.		
Allergy Testing & Treatment	Covered at 90% of the allowed amount, subject to plan year deductible	Covered at 70% of the allowed amount, subject to plan year deductible
Ambulance Service	Covered at 100% of the allowed amount, no copay or deductible	Covered at 100% of the allowed amount, no copay or deductible
Participating Chiropractic Services	Covered at 90% of the allowed amount, subject to plan year deductible	Covered at 70% of the allowed amount, subject to plan year deductible **In Alabama,** not covered
Durable Medical Equipment (DME)	Covered at 90% of the allowed amount, subject to plan year deductible	Covered at 70% of the allowed amount, subject to plan year deductible **In Alabama,** covered at 50% of the allowed amount, subject to plan year deductible
Rehabilitative Occupational, Physical and Speech Therapy Occupational, physical and speech therapy limited to combined maximum of 30 visits per member per plan year	Covered at 90% of the allowed amount, subject to plan year deductible	Covered at 70% of the allowed amount, subject to plan year deductible **In Alabama,** covered at 50% of the allowed amount, subject to plan year deductible

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Habilitative Occupational, Physical and Speech Therapy Occupational, physical and speech therapy limited to combined maximum of 30 visits per member per plan year	Covered at 90% of the allowed amount, subject to plan year deductible	Covered at 70% of the allowed amount, subject to plan year deductible **In Alabama,** covered at 50% of the allowed amount, subject to plan year deductible
Occupational, Physical and Speech Therapy for Autism Spectrum Disorders ages 0-18	Covered at 90% of the allowed amount, subject to plan year deductible	Covered at 70% of the allowed amount, subject to plan year deductible **In Alabama,** covered at 50% of the allowed amount, subject to plan year deductible
Home Health and Hospice	Covered at 90% of the allowed amount, subject to plan year deductible	Covered at 70% of the allowed amount, subject to plan year deductible **In Alabama,** not covered
Skilled Nursing Facility	Covered at 90% of the allowed amount, subject to plan year deductible	Covered at 70% of the allowed amount, subject to plan year deductible
Pediatric Dental Benefits	Covered at 50% of the allowed amount, subject to plan year deductible	Covered at 50% of the allowed amount, subject to plan year deductible
Annual Dental Exam & Cleaning Benefits paid for one annual exam and cleaning up to $100 per Plan Year	Covered at 100% of the allowed amount, no copay or deductible	Covered at 100% of the allowed amount, subject to plan year deductible
Medically Necessary Removal of Impacted Wisdom Teeth	Covered at 100% of the allowed amount, no copay or deductible	Covered at 100% of the allowed amount, subject to plan year deductible
Medically Necessary Orthodontic Services	Covered at 50% of the allowed amount, subject to plan year deductible	Covered at 50% of the allowed amount, subject to plan year deductible

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
HEALTH MANAGEMENT BENEFITS (Includes Mental Health Disorders and Substance Abuse)		
Individual Case Management	Coordinates care in event of catastrophic or lengthy illness or injury. For more information, please call 1-800-821-7231.	
Chronic Condition Management	Coordinates care for chronic conditions such as asthma, diabetes, coronary artery disease, congestive heart failure, chronic obstructive pulmonary disease and other specialized conditions.	
Baby Yourself®	A maternity program; For more information, please call 1-800-222-4379. You can also enroll online at **AlabamaBlue.com/BabyYourself.**	
Contraceptive Management	Covers prescription contraceptives, which include: birth control pills, injectables, diaphragms, IUDs and other non-experimental FDA approved contraceptives; subject to applicable deductibles, copays and coinsurance.	
Air Medical Transport	Air medical transportation to a network hospital near home if hospitalized while traveling more than 150 miles from home; to arrange transportation, call AirMed at 1-877-872-8624.	

Useful Information to Maximize Benefits

- *To maximize your benefits, always use in-network providers for services covered by your health benefit plan. To find in-network providers, check a provider directory, provider finder website **(AlabamaBlue.com)** or call 1-800-810-BLUE (2583).*
- *In-network hospitals, physicians and other healthcare providers have a contract with a Blue Cross and/or Blue Shield Plan for furnishing healthcare services at a reduced price (examples: BlueCard® PPO, PMD). In-network pharmacies are pharmacies that participate with Blue Cross and Blue Shield of Alabama or its Pharmacy Benefit Manager(s). In Alabama, in-network services provided by mental health disorders and substance abuse professionals are available through the Blue Choice Behavioral Health Network. Sometimes an in-network provider may furnish a service to you that is not covered under the contract between the provider and a Blue Cross and/or Blue Shield Plan. When this happens, benefits may be denied or reduced. Please refer to your benefit booklet for the type of provider network that we determine to be an in-network provider for a particular service or supply.*
- *Out-of-network providers generally do not contract with Blue Cross and/or Blue Shield Plans. If you use out-of-network providers, you may be responsible for filing your own claims and paying the difference between the provider's charge and the allowed amount. The allowed amount may be based on the negotiated rate payable to in-network providers in the same area or the average charge for care in the area.*
- *Please be aware that providers/specialists may be listed in a PPO directory or provider finder website, but not covered under this benefit plan. Please check your benefit booklet for more detailed coverage information.*
- *Bariatric Surgery, Gastric Restrictive procedures and complications arising from these procedures are not covered under this plan. Please see your benefit booklet for more detail and for a complete listing of all plan exclusions.*
- *As a participant in the student health plan, you have access to the following services and benefits when you are traveling over 100 miles from home or outside your community: Emergency Medical Evacuation, Repatriation and Emergency Family Assistance Services, Medical, Travel, Safety, and Legal Assistance and additional benefits. Please visit **aes.myahpcare.com** for more information.*
- *AHP Live Care is an independent company that Blue Cross and Blue Shield of Alabama has contracted with to allow you to see board certified professionals discreetly and on your terms at no additional cost. To access these services, please visit **ahplivecare.com** and use the service key and coupon code **AHPFREE**.*
- *Student Assistance Program allows 24/7 access, life and wellbeing resources, online and mobile tools are that are free, if you referred to outside resources, you will be responsible for any costs. For more information, please call 1(855)850-4301.*
- *Please refer to your benefit book or contact Blue Cross directly about coverage for your hospital charges and other related medical services. Approval for air medical transportation services does not mean that hospitalization and other medical expenses will be covered. All coverage determinations for medical benefits are subject to the terms, conditions, limitations and exclusions of the health plan. Air medical transportation services are provided through a contract with AirMed International, LLC, an independent company that does not provide Blue Cross and Blue Shield of Alabama products. Blue Cross is not responsible for any mistakes, errors or omissions that AirMed, its employees or staff members make. Air medical transportation services terminate if coverage by your health plan ends.*

This is not a contract, benefit booklet or Summary Plan Description. Benefits are subject to the terms, limitations and conditions of the group contract (including your benefit booklet). Check your benefit booklet for more detailed coverage information. Please visit our website, AlabamaBlue.com.

Notice of Nondiscrimination

Blue Cross and Blue Shield of Alabama complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. We do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Blue Cross and Blue Shield of Alabama:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages

If you need these services, contact our 1557 Compliance Coordinator. If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person or by mail, fax, or email at: Blue Cross and Blue Shield of Alabama, Compliance Office, 450 Riverchase Parkway East, Birmingham, Alabama 35244, Attn: 1557 Compliance Coordinator, 1-855-216-3144, 711 (TTY), 1-205-220-2984 (fax), 1557Grievance@bcbsal.org (email). If you need help filing a grievance, our 1557 Compliance Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201,
1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Foreign Language Assistance

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-216-3144 (TTY: 711)

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-216-3144 (TTY: 711)번으로 전화해 주십시오.

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-216-3144 (TTY: 711）。

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-216-3144 (TTY: 711).

Arabic: انتباه: إذا كنت تتحدث العربية، توجد خدمات مساعدة فيما يتعلق باللغة، بدون تكلفة، متاحة لك. اتصل بـ 1-855-216-3144 (الهاتف النصي: 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-216-3144 (TTY: 711).

French: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-216-3144 (ATS: 711).

French Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-855-216-3144 (TTY: 711).

Gujarati: ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હોય, તો ભાષા સહાયતા સેવા, તમારા માટે નિઃશુલ્ક ઉપલબ્ધ છે. 1-855-216-3144 પર કૉલ કરો (TTY: 711).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-216-3144 (TTY: 711).

Hindi: ध्यान दें: अगर आपकी भाषा हिंदी है, तो आपके लिए भाषा सहायता सेवाएँ निःशुल्क उपलब्ध हैं। 1-855-216-3144 (TTY: 711) पर कॉल करें।

Laotian: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-855-216-3144 (TTY: 711).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-216-3144 (телетайп: 711).

Portuguese: ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-855-216-3144 (TTY: 711).

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezplatnej pomocy językowej. Zadzwoń pod numer 1-855-216-3144 (TTY: 711).

Turkish: DİKKAT: Eğer Türkçe konuşuyor iseniz, dil yardımı hizmetlerinden ücretsiz olarak yararlanabilirsiniz. 1-855-216-3144 (TTY: 711) irtibat numaralarını arayın.

Italian: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-216-3144 (TTY: 711).

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-855-216-3144（TTY: 711）まで、お電話にてご連絡ください。