



: Tuskegee University- Student Health Plan

Coverage For: Individual + Family Plan Type: PPO



These 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	\$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 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%

* 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 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	

* 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 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 .)		
<ul style="list-style-type: none"> • Acupuncture • Bariatric surgery • Cosmetic surgery • Routine eye care (Adult) 	<ul style="list-style-type: none"> • Hearing aids • Long-term care • Private-duty nursing • Routine foot care 	<ul style="list-style-type: none"> • 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.

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)		Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)																																											
■ The plan's overall deductible	\$150	■ The plan's overall deductible	\$150	■ The plan's overall deductible	\$150																																										
■ Specialist copay/coinsurance	\$15/0%	■ Specialist copay/coinsurance	\$15/0%	■ Specialist copay/coinsurance	\$15/0%																																										
■ Hospital (facility) copay/coinsurance	\$0/10%	■ Hospital (facility) copay/coinsurance	\$0/10%	■ Hospital (facility) copay/coinsurance	\$0/10%																																										
■ Other copay/coinsurance	\$15/10%	■ Other copay/coinsurance	\$15/10%	■ Other copay/coinsurance	\$15/10%																																										
<p>This EXAMPLE event includes services like: Specialist office visits (<i>prenatal care</i>) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests (<i>ultrasounds and blood work</i>) Specialist visit (<i>anesthesia</i>)</p>		<p>This EXAMPLE event includes services like: Primary care physician office visits (<i>including disease education</i>) Diagnostic tests (<i>blood work</i>) Prescription drugs Durable medical equipment (<i>glucose meter</i>)</p>		<p>This EXAMPLE event includes services like: Emergency room care (<i>including medical supplies</i>) Diagnostic tests (<i>x-ray</i>) Durable medical equipment (<i>crutches</i>) Rehabilitation services (<i>physical therapy</i>)</p>																																											
Total Example Cost	\$12,800	Total Example Cost	\$7,400	Total Example Cost	\$1,900																																										
<p>In this example, Peg would pay:</p> <table border="1"> <thead> <tr> <th colspan="2">Cost Sharing</th> </tr> </thead> <tbody> <tr> <td>Deductibles</td> <td>\$150</td> </tr> <tr> <td>Copayments</td> <td>\$20</td> </tr> <tr> <td>Coinsurance</td> <td>\$1240</td> </tr> <tr> <th colspan="2">What isn't covered</th> </tr> <tr> <td>Limits or exclusions</td> <td>\$60</td> </tr> <tr> <td>The total Peg would pay is</td> <td>\$1,470</td> </tr> </tbody> </table>		Cost Sharing		Deductibles	\$150	Copayments	\$20	Coinsurance	\$1240	What isn't covered		Limits or exclusions	\$60	The total Peg would pay is	\$1,470	<p>In this example, Joe would pay:</p> <table border="1"> <thead> <tr> <th colspan="2">Cost Sharing</th> </tr> </thead> <tbody> <tr> <td>Deductibles</td> <td>\$140</td> </tr> <tr> <td>Copayments</td> <td>\$370</td> </tr> <tr> <td>Coinsurance</td> <td>\$0</td> </tr> <tr> <th colspan="2">What isn't covered</th> </tr> <tr> <td>Limits or exclusions</td> <td>\$420</td> </tr> <tr> <td>The total Joe would pay is</td> <td>\$930</td> </tr> </tbody> </table>		Cost Sharing		Deductibles	\$140	Copayments	\$370	Coinsurance	\$0	What isn't covered		Limits or exclusions	\$420	The total Joe would pay is	\$930	<p>In this example, Mia would pay:</p> <table border="1"> <thead> <tr> <th colspan="2">Cost Sharing</th> </tr> </thead> <tbody> <tr> <td>Deductibles</td> <td>\$150</td> </tr> <tr> <td>Copayments</td> <td>\$50</td> </tr> <tr> <td>Coinsurance</td> <td>\$60</td> </tr> <tr> <th colspan="2">What isn't covered</th> </tr> <tr> <td>Limits or exclusions</td> <td>\$0</td> </tr> <tr> <td>The total Mia would pay is</td> <td>\$260</td> </tr> </tbody> </table>		Cost Sharing		Deductibles	\$150	Copayments	\$50	Coinsurance	\$60	What isn't covered		Limits or exclusions	\$0	The total Mia would pay is	\$260
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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 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 નિ:શુલ્ક ઉપલબ્ધ છે. 1-855-216-3144 પર કોલ 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 नि:शुल्क उपलब्ध हैं। 1-855-216-3144 (TTY: 711) पर कॉल करें।

Laotian: ໄປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ຄ່າສັງຄັກ, ຄ່າມາດມີຮ່ວມໃຫ້ທ່ານ. ໂທ 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。