# Auburn University

Coverage For: Individual + Family Plan Type: PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-633-8052 or visit us at www.abuurn.edu. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.bcbsal.org/sbcglossary/ or call 1-800-292-8868 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| What is the overall deductible? | $250 individual; 3 member family maximum. | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. |
| Are there services covered before you meet your deductible? | Yes. Preventive services in-network are covered before you meet your deductible. | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/. |
| Are there other deductibles for specific services? | No. | You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services. |
| What is the out–of–pocket limit for this plan? | For in-network $7,350 individual/$14,700 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.<br>For ABBH call 1-800-677-4544. | This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| Do you need a referral to see a specialist? | No. | You can see the specialist you choose without a referral. |

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness | $30 copay/visit<br>No overall deductible | 20% coinsurance | None |
| | Specialist visit | $35 copay/visit<br>No overall deductible | 20% 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 you need are preventive. Then check what your plan will pay for. |
| If you have a test | Diagnostic test (x-ray, blood work) | 0% coinsurance | 20% coinsurance | Benefits listed are physician services; facility benefits are also available; precertification may be required |
| | Imaging (CT/PET scans, MRIs) | 0% coinsurance | 20% coinsurance | |
| 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 (retail)<br>No overall deductible | $10 copay (retail)<br>No overall deductible | Prior authorization required for specific drugs; member pays the copay plus the difference between the allowance and the actual billed charge for out-of-network outside Alabama; in Alabama, out-of-network not covered; Auburn University will waive $10 copay for all generic medications filled at Auburn University Pharmaceutical Care Center (AUPCC) when employee enrolls and meets requirements in TigerMeds program; generic equivalents mandatory when available; please visit AlabamaBlue.com and go to "pharmacy" for more prescription drug information |
| | Tier 2 Drugs | $20 copay (retail)<br>No overall deductible | $20 copay (retail)<br>No overall deductible | |
| | Tier 3 Drugs | $50 copay (retail)<br>No overall deductible | $50 copay (retail)<br>No overall deductible | |
| | Tier 4 Drugs | $80 copay (retail)<br>No overall deductible | $80 copay (retail)<br>No overall deductible | |
| | Tier 5 Drugs (preferred specialty) | $120 copay (retail)<br>No overall deductible | $120 copay (retail)<br>No overall deductible | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | $200 copay/visit | $200 copay/visit & 20% coinsurance | In Alabama, out-of-network not covered |
| | Physician/surgeon fees | 0% coinsurance | 20% coinsurance | None |
| If you need immediate medical attention | Emergency room care | Accident: $200 copay/visit<br>Medical Emergency: $200 copay/visit | Accident: $200 copay/visit<br>Medical Emergency: $200 copay/visit | Physician charges will apply |

* For more information about limitations and exceptions, see the plan or policy document at www.auburn.edu/payroll

| 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) | |
| | Emergency medical transportation | 30% coinsurance | 30% coinsurance | None |
| | Urgent care | $30 copay/visit<br>No overall deductible | 20% coinsurance | None |
| If you have a hospital stay | Facility fee (e.g., hospital room) | $200 per admission copay | $200 per admission copay & 20% coinsurance | In Alabama, out-of-network not covered; precertification is required for coverage; per admission deductible waived for maternity admission if the member/spouse enrolls in Baby Yourself during the first 16 weeks of pregnancy |
| | Physician/surgeon fees | 0% coinsurance | 20% coinsurance | None |
| If you need mental health, behavioral health, or substance abuse services | Outpatient Services Including:<br>• Outpatient Office Visits<br>• Ambulatory Detoxification | $30 Copay Per Visit/Session/Group Therapy Session<br>No overall deductible | 20% of the allowed amount and all billed charges not covered by the *Plan* | Limited to Up To 30 Visits/Sessions/Group Therapy Sessions (Or Any Combination Thereof) Total For Outpatient Care (Mental Health & Substance Abuse Treatment) Each Plan Year per covered member |
| | Psychological/Neuropsychological Testing | $30 Copay Per Hour of Testing<br>No overall deductible | 20% of the allowed amount and all billed charges not covered by the *Plan* | Precertification Required Call American Behavioral at 800-677-4544<br><br>Limited To Five (5) Hours Of Psychological/ Neuropsychological Testing Each Plan Year; per covered member |
| | Applied Behavior Analysis for Treatment of Autism Spectrum Disorder | Ages 0-9: Up to $20,000 per eligible child per calendar year<br>Ages 10-13: Up to $15,000 per eligible child per calendar year<br>Ages 14-18: Up to $10,000 per eligible child per calendar year | No Out-of-Network Benefit | Precertification Required Call American Behavioral at 800-677-4544 |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you need mental health, behavioral health, or substance abuse services-- *Continued* | Inpatient Hospital Services Including:<br><br>• Inpatient Hospitalization<br>• Electroconvulsive Therapy (ECT) Treatment<br>• Partial Hospitalization Program (PHP)<br>• Intensive Outpatient Program (IOP) | $200 Copay Per Admission | 20% of the allowed amount and all billed charges not covered by the *Plan* | Pre-Admission Certification Required<br>Call American Behavioral at 800-677-4544<br><br>Up To 30 Days Total For Inpatient Care (Mental Health & Substance Abuse Treatment) Each 12 Consecutive Months per covered member<br><br>2 PHP Days = 1 Inpatient Day<br>2 IOP Days = 1 Inpatient Day |
| | Substance Abuse Program Including:<br><br>• Detoxification<br>• Rehabilitation<br>• PHP | $200 Copay Per Admission | No Out-of-Network Benefit | Pre-Admission Certification Required<br>Call American Behavioral at 800-677-4544<br><br>Substance Abuse Treatment = Once Per Lifetime per covered member<br><br>Treatment Applies To Inpatient Hospital Services<br><br>Up To 30 Days Total Combined Inpatient Detoxification, Rehabilitation, And PHP per covered member |
| | Inpatient Physician Services In Conjunction With an Approved Inpatient Hospitalization | None | 20% of the allowed amount and all billed charges not covered by the *Plan* | Limited to Up To 30 Days Total For Inpatient Care (Mental Health and Substance Abuse Treatment) Each 12 Consecutive Months per covered member |
| | Anesthesia In Conjunction With ECT Treatment | Subject to the Inpatient Copayment Amount | 20% of the allowed amount and all billed charges not covered by the *Plan* | |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you are pregnant | Office visits | 0% coinsurance | 20% 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) |
| | Childbirth/delivery professional services | 0% coinsurance | 20% coinsurance | |
| | Childbirth/delivery facility services | $200 per admission copay | $200 per admission copay & 20% coinsurance | |
| If you need help recovering or have other special health needs | Home health care | 0% coinsurance | 30% coinsurance | In Alabama, out-of-network not covered; precertification may be required |
| | Rehabilitation services | 30% 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 per covered member |
| | Habilitation services | 30% coinsurance | 30% coinsurance | |
| | Skilled nursing care | Not Covered | Not Covered | Not covered; member pays 100% |
| | Durable medical equipment | 30% coinsurance | 30% coinsurance | None |
| | Hospice services | 0% 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<br>No overall deductible | Not Covered | Please visit AlabamaBlue.com/preventiveservices |
| | Children's glasses | Not Covered | Not Covered | Not covered; member pays 100% |
| | Children's dental check-up | No Charge<br>No overall deductible | Not Covered | Please visit AlabamaBlue.com/preventiveservices |

## Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

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

* For more information about limitations and exceptions, see the plan or policy document at www.auburn.edu/payroll

| Other Covered Services (Limitations MAY apply to these services. This isn't a complete list. Please see your plan document.) | |
|---|---|
| • Bariatric surgery (only morbid obesity in limited circumstances) | • Infertility treatment (Assisted Reproductive Technology not covered) |
| • Chiropractic care | • Non-emergency care when traveling outside the U.S. |

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323 x61565 or www.cciio.cms.gov. If coverage is insured, contact your State insurance regulator regarding your possible rights to continuation coverage under State Law. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Blue Cross and Blue Shield of Alabama at 1-800-633-8052.

Does this plan provide Minimum Essential Coverage? **Yes**
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 and are not true benefits through Auburn University. 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 | $250 | ■ The plan's overall deductible | $250 | ■ The plan's overall deductible | $250 |
| ■ Specialist copay/coinsurance | $35/0% | ■ Specialist copay/coinsurance | $35/0% | ■ Specialist copay/coinsurance | $35/0% |
| ■ Hospital (facility) copay/coinsurance | $0/0% | ■ Hospital (facility) copay/coinsurance | $0/0% | ■ Hospital (facility) copay/coinsurance | $0/0% |
| ■ Other copay/coinsurance | $30/30% | ■ Other copay/coinsurance | $30/30% | ■ Other copay/coinsurance | $30/30% |
| This EXAMPLE event includes services like:<br>Specialist office visits (*prenatal care)*<br>Childbirth/Delivery Professional Services<br>Childbirth/Delivery Facility Services<br>Diagnostic tests (*ultrasounds and blood work)*<br>Specialist visit *(anesthesia)* | | This EXAMPLE event includes services like:<br>Primary care physician office visits (*including disease education)*<br>Diagnostic tests *(blood work)*<br>Prescription drugs<br>Durable medical equipment *(glucose meter)* | | This EXAMPLE event includes services like:<br>Emergency room care *(including medical supplies)*<br>Diagnostic tests *(x-ray)*<br>Durable medical equipment *(crutches)*<br>Rehabilitation services *(physical therapy)* | |
| Total Example Cost | $12,800 | Total Example Cost | $7,400 | Total Example Cost | $1,900 |
| In this example, Peg would pay: | | In this example, Joe would pay: | | In this example, Mia would pay: | |
| *Cost Sharing* | | *Cost Sharing* | | *Cost Sharing* | |
| Deductibles* | $250 | Deductibles* | $250 | Deductibles* | $250 |
| Copayments | $230 | Copayments | $700 | Copayments | $100 |
| Coinsurance | $0 | Coinsurance | $0 | Coinsurance | $170 |
| *What isn't covered* | | *What isn't covered* | | *What isn't covered* | |
| Limits or exclusions | $60 | Limits or exclusions | $420 | Limits or exclusions | $0 |
| The total Peg would pay is | $540 | The total Joe would pay is | $1,370 | The total Mia would pay is | $520 |

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: www.auburn.edu/healthytigers.
*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

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

***Language Access Services and Notice of Nondiscrimination only apply to administrative services that Blue Cross and Blue Shield of Alabama provides to your employer.***

## 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 □□□□□□□ 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 □□□□□ 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。