

City of Tuscaloosa
BlueCard[®] PPO

Effective October 1, 2015

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BENEFIT	IN-NETWORK	OUT-OF-NETWORK
<i>Benefit payments are based on the amount of the provider's charge that Blue Cross and Blue Shield recognizes for payment of benefits. The allowed amount may vary depending upon the type provider and where services are received. Some services require a copay, coinsurance, calendar year deductible or deductible for each admission, visit or service.</i>		
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 <i>Note:</i> Inpatient hospital deductibles and copays do not apply to the Calendar Year Out-of-Pocket Maximum.	Covered at 100% after \$250 per admission deductible; \$50 per day hospital copay days 2-11 for each admission	Covered at 80% after \$500 per admission deductible <i>Note:</i> In Alabama, available only for accidental injury
Inpatient Physician Visits and Consultations	Covered at 100%; no copay or deductible	Covered at 80% subject to calendar year deductible; in Alabama covered at 50% subject to calendar year deductible Mental Health Disorders and Substance Abuse Services covered at 80% not subject to calendar year deductible
OUTPATIENT HOSPITAL BENEFITS		
(Includes Mental Health Disorders and Substance Abuse)		
Precertification is required for some outpatient hospital benefits and physician-administered drugs; please see your benefit booklet. If precertification is not obtained, no benefits are available.		
Outpatient Surgery (Including Ambulatory Surgical Centers)	Covered at 100% after \$25 hospital copay	Covered at 80% subject to calendar year deductible; in Alabama, not covered
Emergency Room (Medical Emergency)	Covered at 100% after \$50 hospital copay	Covered at 80% subject to calendar year deductible; in Alabama, not covered Mental Health Disorders and Substance Abuse Services covered at 100% after \$50 hospital copay; in Alabama, not covered
Emergency Room (Accident)	Covered at 100%; no copay or deductible	Covered at 100%; no copay or deductible for services within 72 hours, thereafter 80% subject to calendar year deductible
Emergency Room Physician	Covered at 100% after \$35 physician copay	Covered at 80% subject to calendar year deductible; in Alabama covered at 50% subject to calendar year deductible Mental Health Disorders and Substance Abuse Services covered at 100% after \$35 physician copay
Outpatient Diagnostic Lab, X-ray, Pathology, Dialysis, IV Therapy, Chemotherapy & Radiation Therapy	Covered at 100%; no copay or deductible	Covered at 80% subject to calendar year deductible; in Alabama, not covered
Intensive Outpatient Program (IOP) and Partial Hospitalization Program (PHP)	Covered at 100% after \$35 daily hospital copay	Covered at 80% subject to calendar year deductible; in Alabama, not covered
PHYSICIAN BENEFITS		
(Includes Mental Health Disorders and Substance Abuse)		
Precertification is required for some physician benefits and physician-administered drugs; please see your benefit booklet. If precertification is not obtained, no benefits are available.		
Office Visits & Consultations	Covered at 100% after \$35 physician copay	Covered at 80% subject to calendar year deductible
Surgery & Anesthesia	Covered at 100%; no copay or deductible	Covered at 80% subject to calendar year deductible
Maternity Care	Covered at 100%; no copay or deductible	Covered at 80% subject to calendar year deductible
Diagnostic Lab, X-ray, Pathology, Dialysis, IV Therapy, Chemotherapy & Radiation Therapy	Covered at 100%; no copay or deductible	Covered at 80% subject to calendar year deductible
Note: In Alabama, Out-of-Network physician services covered at 50% subject to calendar year deductible		

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
PREVENTIVE CARE BENEFITS		
Routine Newborn Exam (in hospital)	Covered at 100%; no copay or deductible	Not covered
Routine Well Child Care Exams Nine visits during first 24 months of life and one visit per year thereafter through age six	Covered at 100% after \$35 physician copay	Not covered
Routine Developmental Screening Three exams between 9 months and 30 months of life	Covered at 100%; no copay or deductible	Not covered
Routine Immunizations <ul style="list-style-type: none"> • Age limitations apply to certain immunizations • Certain immunizations may also be obtained through the Pharmacy Vaccine Network. See AlabamaBlue.com/pharmacy for more information 	Covered at 100%; no copay or deductible	Not covered
Routine Office Visit When eligible for routine pap smear, routine mammogram, or routine PSA/Digital Rectal exam	Covered at 100% after \$35 physician copay	Not covered
Routine Pap Smear One per calendar year	Covered at 100%; no copay or deductible	Not covered
Routine Human Papillomavirus (HPV) Testing One routine test every three calendar years for females ages 30 and over	Covered at 100%; no copay or deductible	Not covered
Routine Chlamydia Screening One per calendar year for females ages 15-24	Covered at 100%; no copay or deductible	Not covered
Routine Hepatitis C Screening Once in a lifetime for members born between 01/01/1945 and 12/31/1965	Covered at 100%; no copay or deductible	Not covered
Routine/Screening Mammogram One exam for females ages 35-39 and one per calendar year for females ages 40 and over	Covered at 100%; no copay or deductible	Not covered
Routine Prostate Cancer Screening Males age 40 and over <ul style="list-style-type: none"> • Prostate Specific Antigen (PSA) each calendar year • Digital Rectal Exam each calendar year 	Covered at 100%; no copay or deductible	Not covered
Routine Colorectal Cancer Screening Ages 50 and over <ul style="list-style-type: none"> • Hemocult stool check/Fecal occult blood test each calendar year • Flexible sigmoidoscopy every three calendar years • Double-contrast barium enema every five calendar years • Colonoscopy every 10 calendar years 	Covered at 100%; no copay or deductible for physician charges (outpatient hospital services may require a copay)	Not covered
Note: In case of illness or family history of cancer, services generally are not considered preventive and may be covered by other plan provisions		

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
PRESCRIPTION DRUG BENEFITS (Includes Mental Health Disorders and Substance Abuse)		
Prescription Drug Card <ul style="list-style-type: none"> • Non-maintenance - up to 30 day supply with one copay • Maintenance List Drugs - up to a 60 day supply with one copay • Specialty drugs limited to 30 day supply • Some copays combined for diabetic supplies • Certain specialty drugs can only be dispensed by a Participating Specialty Pharmacy • Specialty Drugs, or biotech drugs, are generally high cost self-administered drugs • View the Standard Prescription Drug list that applies to the plan at AlabamaBlue.com/web/pharmacy/drugguide.html Prescription Drug deductible combined for retail and Mail Order drugs • From time to time, certain drugs in certain drug categories on the Standard Prescription Drug list are excluded from coverage under the plan. View the Drug Exclusion Strategy-Alternative Drug List that also applies to the plan at AlabamaBlue.com/web/pharmacy/drugguide/html. This list will be updated periodically. 	Participating Pharmacy: Separate \$100 prescription drug deductible per person per calendar year (no family maximum); each prescription purchased from Participating Pharmacy covered at 100% after deductible subject to the following copays: Tier 1 Drugs: \$15 copay per prescription Tier 2 Drugs: \$40 copay per prescription Tier 3 Drugs: \$55 copay per prescription	Not covered
Mail Order Pharmacy Benefits <ul style="list-style-type: none"> • Up to 90-day supply with one copay • Mail Order drugs are available through PrimeMail[®] (Enroll online at AlabamaBlue.com or call 1-800-391-1886) • Specialty Drugs are not available through mail order • Prescription Drug deductible combined for retail and Mail Order drugs 	Separate \$100 prescription drug deductible per person per calendar year (no family maximum); each prescription purchased from Participating Pharmacy covered at 100% after deductible subject to the following copays: Tier 1 Drugs: \$15 copay per prescription Tier 2 Drugs: \$40 copay per prescription Tier 3 Drugs: \$55 copay per prescription	Not covered
SUMMARY OF COST SHARING PROVISIONS (Includes Mental Health Disorders and Substance Abuse)		
Calendar Year Deductible	\$325 individual; \$975 aggregate maximum per family 4 TH Quarter Carryover Deductible: Any covered expenses incurred in the last 3 months of any benefit period which have been allocated toward all or a portion of the Calendar year Deductible for that year may also be allocated toward next years Calendar year Deductible.	
Calendar Year Out-of-Pocket Maximum Applies to: <ul style="list-style-type: none"> • Other Covered Services • Home Health and Hospice 	\$400 individual plus calendar year deductible Only the coinsurance amounts you pay for the listed services will apply to the maximum. Fixed copays do not apply to the maximum. After you reach the Calendar Year Out-of-Pocket Maximum, applicable expenses are covered at 100% for the remainder of the calendar year.	

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
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 80% subject to calendar year deductible	Covered at 80% subject to calendar year deductible
Ambulance Service	Covered at 80% subject to calendar year deductible	Covered at 80% subject to calendar year deductible
Cancer Diagnosed Treatment	Covered at 100%; no copay or deductible	Covered at 100%; no copay or deductible; in Alabama, covered at 50% subject to calendar year deductible
Chiropractic Services	Covered at 80% subject to calendar year deductible	Covered at 80% subject to calendar year deductible
Durable Medical Equipment (DME)	Covered at 80% subject to calendar year deductible	Covered at 80% subject to calendar year deductible
Occupational Therapy Limited to certain services related to hand and lymphedema	Covered at 80% subject to calendar year deductible	Covered at 80% subject to calendar year deductible
Physical Therapy	Covered at 80% subject to calendar year deductible	Covered at 80% subject to calendar year deductible
Home Health and Hospice	Covered at 100%; no copay or deductible	Covered at 80% subject to calendar year deductible; in Alabama, not covered
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.	
Disease Management	Coordinates care for chronic conditions such as asthma, diabetes, coronary artery disease, congestive heart failure and chronic obstructive pulmonary disease.	
Baby Yourself[®]	A maternity program; For more information, please call 1-800-222-4379. You can also enroll online at BeHealthy.com .	
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.	

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 Blue Cross and Blue Shield of Alabama or another Blue Cross and/or Blue Shield Plan for furnishing healthcare services at a reduced price (examples: BlueCard PPO, PMD, Preferred Care). 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.
- Out-of-network providers generally do not contract with Blue Cross and Blue Shield of Alabama or another Blue Cross and/or Blue Shield Plan. 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.
- In-network Certified Registered Nurse Practitioners (CRNPs) /Certified Nurse Midwives (CNMs) are considered eligible providers; no coverage out-of-network for services provided by CRNPs and CNMs.

Your group believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act. As permitted by the Affordable Care Act, this plan does not have to include certain consumer protections of the Affordable Care Act that apply to non-grandfathered plans. This is not a contract, benefit booklet or a Summary Plan Description. Benefits are subject to the terms, limitations and conditions of the group contract. Please visit our website, AlabamaBlue.com.