



: City of Tuscaloosa Option 1

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 [Tuscaloosa.com](http://Tuscaloosa.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/](http://www.bcbsal.org/sbcglossary/) or call 1-800-292-8868 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$325 individual/\$975 family.	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive services</a> in-network are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply.
Are there other <a href="#">deductibles</a> for specific services?	Yes. \$100 for <a href="#">prescription drug coverage</a> . \$250 per admission. \$500 per admission for out-of-network. There are no other specific <a href="#">deductibles</a> .	You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this plan begins to pay for these services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$400 individual.	The <a href="#">out-of-pocket limits</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limits</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , balance-billed charges, health care this <a href="#">plan</a> doesn't cover, <a href="#">copays</a> , <a href="#">cost sharing</a> for most out-of-network benefits, <a href="#">deductibles</a> and pharmacy <a href="#">copays</a> .	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://AlabamaBlue.com">AlabamaBlue.com</a> or call 1-800-810-BLUE for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider</a> network. You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan</a> 's network. You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> 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)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	\$35 <a href="#">copay</a> /visit No overall <a href="#">deductible</a>	20% <a href="#">coinsurance</a>	In Alabama, <a href="#">out-of-network coinsurance</a> is 50%; precertification is required for some provider-administered drugs; if no precertification is obtained, no benefits are available  Age and visit limitations apply; facility charges may apply; you may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
	<a href="#">Specialist</a> visit	\$40 <a href="#">copay</a> /visit No overall <a href="#">deductible</a>	20% <a href="#">coinsurance</a>	
	<a href="#">Preventive care/screening/immunization</a>	\$35 <a href="#">copay</a> /visit No overall <a href="#">deductible</a>	Not Covered	
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	No Charge No overall <a href="#">deductible</a>	20% <a href="#">coinsurance</a>	Benefits listed are <a href="#">physician services</a> ; in Alabama, <a href="#">out-of-network coinsurance</a> is 50%; facility benefits are also available; precertification may be required; if no precertification is obtained, no benefits are available
	Imaging (CT/PET scans, MRIs)	No Charge No overall <a href="#">deductible</a>	20% <a href="#">coinsurance</a>	
<b>If you need drugs to treat your illness or condition</b>  More information about <a href="#">prescription drug coverage</a> is available at <a href="#">AlabamaBlue.com/pharmacy</a>	Tier 1 Drugs	\$15 <a href="#">copay</a> (retail) \$15 <a href="#">copay</a> (mail order)	Not Covered	Precertification required for specific drugs; if no precertification is obtained, no benefits are available; subject to drug <a href="#">deductible</a>
	Tier 2 Drugs	\$45 <a href="#">copay</a> (retail) \$45 <a href="#">copay</a> (mail order)	Not Covered	
	Tier 3 Drugs	\$65 <a href="#">copay</a> (retail) \$65 <a href="#">copay</a> (mail order)	Not Covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$25 <a href="#">copay</a> No overall <a href="#">deductible</a>	20% <a href="#">coinsurance</a>	In Alabama, out-of-network not covered; precertification may be required; if no precertification is obtained, no benefits are available
	Physician/surgeon fees	No Charge No overall <a href="#">deductible</a>	20% <a href="#">coinsurance</a>	In Alabama, <a href="#">out-of-network coinsurance</a> is 50%
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	Accident: No Charge No overall <a href="#">deductible</a> Medical Emergency: \$65 <a href="#">copay</a> /visit No overall <a href="#">deductible</a>	Accident: No Charge No overall <a href="#">deductible</a> Medical Emergency: \$65 <a href="#">copay</a> /visit No overall <a href="#">deductible</a>	Physician charges apply

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [Tuscaloosa.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)	
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	None
	<a href="#">Urgent care</a>	\$40 <a href="#">copay</a> /visit No overall <a href="#">deductible</a>	20% <a href="#">coinsurance</a>	In Alabama, <a href="#">out-of-network coinsurance</a> is 50%
If you have a hospital stay	Facility fee (e.g., hospital room)	\$250 per admission <a href="#">deductible</a> & \$50 <a href="#">copay</a> /day days 2-11 No overall <a href="#">deductible</a>	\$500 per admission <a href="#">deductible</a> & 20% <a href="#">coinsurance</a> No overall <a href="#">deductible</a>	In Alabama, out-of-network benefits are only available for accidental injury; precertification is required; if no precertification is obtained, no benefits are available
	Physician/surgeon fees	No Charge No overall <a href="#">deductible</a>	20% <a href="#">coinsurance</a>	In Alabama, <a href="#">out-of-network coinsurance</a> is 50%; precertification is required; if no precertification is obtained, no benefits are available
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Physician: \$35 <a href="#">copay</a> /visit Intensive Outpatient/Partial <a href="#">Hospitalization</a> : No Charge No overall <a href="#">deductible</a>	20% <a href="#">coinsurance</a>	In Alabama, <a href="#">out-of-network coinsurance</a> is 50% for <a href="#">physician services</a> ; precertification is required for intensive outpatient, partial <a href="#">hospitalization</a> and inpatient <a href="#">hospitalization</a> ; if no precertification is obtained, no benefits are available
	Inpatient services	Physician: No Charge Inpatient Hospital: \$250 per admission <a href="#">deductible</a> & \$50 <a href="#">copay</a> /day days 2-11 No overall <a href="#">deductible</a>	Physician: 20% <a href="#">coinsurance</a> Inpatient Hospital: \$500 per admission <a href="#">deductible</a> & 20% <a href="#">coinsurance</a> No overall <a href="#">deductible</a>	
If you are pregnant	Office visits	No Charge No overall <a href="#">deductible</a>	20% <a href="#">coinsurance</a>	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of services, a <a href="#">copayment</a> , <a href="#">coinsurance</a> or <a href="#">deductible</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound); in Alabama, <a href="#">out-of-network coinsurance</a> is 50% for professional services; precertification may be required for some inpatient services; if no precertification is obtained, no benefits are available
	Childbirth/delivery professional services	No Charge No overall <a href="#">deductible</a>	20% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	\$250 per admission <a href="#">deductible</a> & \$50 <a href="#">copay</a> /day days 2-11 No overall <a href="#">deductible</a>	\$500 per admission <a href="#">deductible</a> & 20% <a href="#">coinsurance</a> No overall <a href="#">deductible</a>	

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [Tuscaloosa.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	<a href="#">Home health care</a>	No Charge No overall <a href="#">deductible</a>	20% <a href="#">coinsurance</a>	In Alabama, out-of-network not covered; benefits are also available for home infusion services; precertification is required outside Alabama; if no precertification is obtained, no benefits are available
	<a href="#">Rehabilitation services</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Benefits listed are for occupational and physical therapy; occupational therapy is limited to certain services related to hand and lymphedema; speech therapy is not covered; children ages 0-18 with an autistic diagnosis are allowed unlimited visits for occupational, physical and speech therapy
	<a href="#">Habilitation services</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	
	<a href="#">Skilled nursing care</a>	Not Covered	Not Covered	Not covered; member pays 100%
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Precertification may be required; if no precertification is obtained, no benefits are available
	<a href="#">Hospice services</a>	No Charge No overall <a href="#">deductible</a>	20% <a href="#">coinsurance</a>	In Alabama, out-of-network not covered; precertification is required outside Alabama; if no precertification is obtained, no benefits are available
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not covered; member pays 100%
	Children's glasses	Not Covered	Not Covered	Not covered; member pays 100%
	Children's dental check-up	Not Covered	Not Covered	Not covered; member pays 100%

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [Tuscaloosa.com](#).

## 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)
- Dental check-up, child
- Eye exam, child
- Glasses, child
- Hearing aids
- Infertility treatment (Assisted Reproductive Technology not covered)
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Skilled nursing care
- Weight loss programs

### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- Bariatric surgery (only for morbid obesity in limited circumstances)
- 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](http://www.cciio.cms.gov) or Blue Cross and Blue Shield of Alabama at 1-800-292-8868. 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](http://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 on how 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 1-800-292-8868.

### Does this [plan](#) provide Minimum Essential Coverage? **Yes**

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

### Does this [plan](#) meet Minimum Value Standards? **Yes**

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

*To see examples of how this [plan](#) might cover costs for a sample medical situation see the next section.*

## 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 <a href="#">plan's</a> overall <a href="#">deductible</a> \$325	■ The <a href="#">plan's</a> overall <a href="#">deductible</a> \$325	■ The <a href="#">plan's</a> overall <a href="#">deductible</a> \$325
■ <a href="#">Specialist copay</a> \$40	■ <a href="#">Specialist copay</a> \$40	■ <a href="#">Specialist copay</a> \$40
■ Hospital (facility) <a href="#">copay</a> \$50	■ Hospital (facility) <a href="#">copay</a> \$50	■ Hospital (facility) <a href="#">copay</a> \$50
■ Other <a href="#">copay/coinsurance</a> \$45/20%	■ Other <a href="#">copay/coinsurance</a> \$45/20%	■ Other <a href="#">copay/coinsurance</a> \$45/20%

### 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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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### In this example, Peg would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$10
<a href="#">Copayments</a>	\$400
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$470</b>

### 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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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### In this example, Joe would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$300
<a href="#">Copayments</a>	\$800
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$40
<b>The total Joe would pay is</b>	<b>\$1,140</b>

### This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)  
[Diagnostic tests](#) (*x-ray*)  
[Durable medical equipment](#) (*crutches*)  
[Rehabilitation services](#) (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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### In this example, Mia would pay:

Cost Sharing	
<a href="#">Deductibles</a> *	\$330
<a href="#">Copayments</a>	\$80
<a href="#">Coinsurance</a>	\$300
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$710</b>

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](http://AlabamaBlue.com).

\*Note: This [plan](#) has other [deductibles](#) for specific services included in this coverage example. See "Are there other [deductibles](#) for specific services?" row above.

