USA Health & Dental Plan

Base Plan

SouthFlex
Premium Conversion

Effective January 1, 2017

BASE PLAN
APPLIES TO EMPLOYEES OF THE UNIVERSITY OF SOUTH ALABAMA AND USA HEALTH CARE MANAGEMENT, LLC EMPLOYED PRIOR TO JANUARY 1, 2013

MEMBER HANDBOOK
THE USA HEALTH & DENTAL PLAN – BASE PLAN OF BENEFITS

The USA Health & Dental Plan is sponsored by the University of South Alabama. The University supports the USA Health & Dental Plan with an employer contribution. The Plan is governed by the Management Committee with oversight by the Fringe Benefits Committee. The USA Health & Dental Plan covers all eligible employees and eligible dependents when dependent coverage is elected by the employee. The USA Health & Dental Plan also allows participation by USA HealthCare Management, LLC for its eligible employees and dependents.

The USA Health & Dental Plan is designed to comply with all required state and federal laws and acts governing the operation of an employer sponsored group health plan. The Base Plan is a “Grandfathered Plan” under the Affordable Care Act and as such is not required to comply with all requirements of the Act. The Base Plan is not covered by the Employee Retirement Income Security Act of 1974 commonly referred to as ERISA.

The USA Health & Dental Plan is designed to assist you with the costs of medical care. The Plan does not pay for all of your medical expenses. You are required to contribute towards the cost of single and family coverage by making a monthly contribution towards the cost of the Plan. You are also required to pay deductibles, coinsurance, copays and expenses that are not covered by the Plan. The Plan contains limitations and exclusions for some services and expenses and this booklet will assist you in understanding these limitations. You and your physician or medical provider ultimately decide on the medical treatment that best manages your medical condition and this may include medical care that is not covered by the Plan.

SELF-FUNDING BENEFITS

The benefits provided to you and your eligible dependents by the USA Health & Dental Plan are self-funded. The University of South Alabama and eligible employees pay the cost of all benefits. This funding method is designed to reduce cost for you and for the University of South Alabama.

Employee eligibility is managed by the University’s Human Resources Department and the University contracts with the Claim Administrators, Blue Cross Blue Shield of Alabama (BCBS) for medical and dental benefits and Express Scripts, Inc. (ESI) for pharmacy benefits, to process claims and pay benefits.

Self-funding places responsibility upon all of us to spend money for benefits with the same care we would use in spending our own money. There is a limit to the benefit dollars available. Prudent use of health care services will preserve those benefit dollars. We must be aware of the cost of health care and act as wise health care consumers when spending our money.

MEMBER HANDBOOK

This USA Health & Dental Plan Member Handbook has been prepared in an easy-to-read format to assist you with understanding the Plan. It describes the benefits available under the Base Plan. Certain words and terms have specific meaning and are capitalized when used. These are explained in the definitions section or within the context of this booklet.

The USA Health & Dental Plan Management Committee reserves the right to interpret, amend or change the Plan, terminate any or all benefits and to make final determinations with regard to all matters concerning the Plan.

Limitations and exclusions apply to some medical conditions and services. Most of the Plan’s exclusions, limitations and provisions are described in this Member Handbook.

BASE PLAN – STANDARD PLAN

This Member Handbook describes the Base Plan which applies to employees who were employed prior to January 1, 2013. Employees employed on and after January 1, 2013, are eligible for the Standard Plan. The Standard Plan is described in a separate Member Handbook.
USA HEALTH & DENTAL PLAN – CONTACT INFORMATION

ADDITIONAL INFORMATION
For questions concerning eligibility and enrollment, change-in-status events, assistance in making application for coverage contact:

HUMAN RESOURCES DEPARTMENTS
University of South Alabama Campus............................... (251) 460-6133
USA Medical Center......................................................(251) 471-7325
USA Children’s and Women’s Hospital............................ (251) 415-1604
Website........................................................................www.southalabama.edu/hr

USA HEALTH
Help Line........................................................................(251) 460-7862
Website................................................................. www.usahealthsystem.com
Physician Directory......... www.usahealthsystem.com/physiciandirectory

MEDICAL & DENTAL: Questions concerning medical and dental benefits and claims payment contact –

BLUE CROSS BLUE SHIELD OF ALABAMA
450 RIVERCHASE PARKWAY EAST
BIRMINGHAM, AL  35244-2858
Customer Service ........................................................1-877-345-6171
Website.................................................................www.AlabamaBlue.com
Preadmission Certification (205) 988-2245 or 1-800-248-2342
BlueCard PPO .........................................................1-800-810-2583
BlueCard PPO Website...........................................http://provider.bcbs.com
SouthFlex – HealthEquity Customer Service.............1-877-288-0719

PHARMACY: Questions concerning pharmacy benefits and claims payment contact –

EXPRESS SCRIPTS, INC.
P.O. BOX 66568
ST LOUIS, MO 63166-6568
Customer Service .....................................................1-855-687-3857
USA Web Address ...............................................www.express-scripts.com/USAJAGS
Home Delivery .............................................. Call 1-800-698-3757 or express-scripts.com
Activate Your Online Benefits ..............................www.express-scripts.com/activate

ADMINISTRATION: There are two administrators managing the USA Health & Dental Plan. You should have two (2) identification cards if you participate in the Plan; one for the health and dental benefits and one for the pharmacy benefit. Show the ESI prescription drug card at the pharmacy and doctor’s office and the BCBS identification card at the doctor’s office and all other medical providers.

MEDICAL & DENTAL: Administered by Blue Cross Blue Shield of Alabama (BCBS)
PHARMACY: Administered by Express Scripts, Inc. (ESI)
EMPLOYEE AND MEMBER RESPONSIBILITY

RESPONSIBILITIES TO THE PLAN

Employees and Eligible Dependents have obligations to the USA Health & Dental Plan. These responsibilities are designed to ensure all benefits and eligibility rules are applied equally and fairly to all Members. It is important that you fulfill your responsibility in part by reading this Member Handbook. It will explain your rights to benefits and your obligations to the Plan.

EMPLOYEE RESPONSIBILITIES

1. Each Employee is responsible for providing to the Human Resources Department and the Claims Administrator the information necessary for the purpose of administering the Plan. Payment of benefits is conditioned upon the Plan promptly receiving the complete information necessary to provide benefits.

2. The Employee is responsible for submitting an application for coverage on the form provided by the Human Resources Department. An application must also be submitted to add or remove dependents. Addition or removal of dependents is not done automatically, and can be accomplished only through proper completion and acceptance of the application by the Human Resources Department.

3. Application must be filed with the Human Resources Department within 30 days of employment or within 30 days of a Change-In-Status Event.

4. Additional information requested by the Human Resources Department must be provided in writing within 30 days.

5. The Employee is responsible for notifying the Human Resources Department of any Change-In-Status Event. Failure to report an event causing the dependent to no longer qualify as an Eligible Dependent will result in the Employee becoming liable for benefits paid by the Plan on behalf of that individual. Example, a divorced spouse has coverage terminate the last day of the month in which the divorce is finalized. An Employee who fails to notify the Human Resources Department of a divorce will be responsible for reimbursing the University for benefits paid on behalf of the divorced spouse incurred after the date of divorce.

MEMBER RESPONSIBILITIES

Each Member is responsible for adhering to the following requirements:

1. Carefully reading this Member Handbook to ensure an understanding of the Plan’s eligibility rules, benefits, provisions and limitations.

2. Checking with the medical provider prior to receiving any services to verify the provider is a Network Provider and medical services are Covered Services.

3. Following requirements for Precertification.

4. Filing a claim, if required, within 12 months of the date of service. Refer to the section titled How to File a Claim.

5. Assisting the Claims Administrator with coordination of benefits, the Plan’s right of subrogation, right of reimbursement and right of recovery of payments made in error. Payment of benefits is conditioned upon the Plan promptly receiving the complete information necessary to provide benefits.

6. Timely notification to the Human Resources Department when a Member ceases to be an Eligible Dependent or becomes eligible for Medicare.

7. Following the requirements for claim review when a claim has been denied.

Failure to fulfill your obligations to the Plan may result in the denial of benefits in whole or in part or your financial liability to reimburse the Plan for any benefits paid due to your failure to provide required information to the Plan in a timely manner.

USA Human Resources Department
(251) 460-6133
The USA Health & Dental Plan has been designed to protect you and your family from significant financial loss due to illness or injury. It is also designed to promote health and provide for medical and dental care at a reasonable cost, while providing Members freedom of choice in selection of health care providers.

Not all federal laws and acts apply to non-federal governmental plans by election. The USA Health & Dental Plan has elected not to participate in all federal regulations and this is especially true for mental health and substance abuse treatment benefits. You should always check your recommended medical treatment with Blue Cross Blue Shield to be sure of the benefits available.

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Group Numbers: 13515 – Base Plan – USA  
86113 – Base Plan – USA HCM  
78380 – Standard Plan – USA  
79873 – Standard Plan – USA HCM
ELIGIBILITY AND ENROLLMENT

BASE PLAN ELIGIBILITY
The Base Plan applies to employees of the University of South Alabama and USA HealthCare Management, LLC who were employed prior to January 1, 2013. Employees who are in a benefits eligible position based on the USA Health & Dental Plan Eligibility Policy are offered this coverage and may elect to cover Eligible Dependents. The employee must also elect single or family coverage authorizing payment of the required monthly cost sharing amount.

The USA Health & Dental Plan Eligibility Policy is intended to comply with the Affordable Care Act which requires an offer of coverage to all employees credited with 30 hours of service per week or 130 hours of service per month on average. Coverage may start the later of the first of the month following the employee’s start date or the first of the month following the date the application for coverage is received by the Human Resources Department.

The USA Health & Dental Plan determines hours of service based on the employer records and may defer the offer of coverage if the employee is determined to be “seasonal” or having “variable hours” in which case benefits eligible status will be determined using a 12 month measurement period for a 12 month stability period in compliance with the Affordable Care Act. The 12 month measurement period runs from October 1st through September 30th of each year for the stability period January 1st through December 31st of the following year.

APPLICATION FOR COVERAGE REQUIRED
You must complete an Application for coverage and file it with the Human Resources Department within 30 days of your first day of employment. You may elect to cover your Eligible Dependents at this time. Eligible Dependents include only those persons listed on the Application form and accepted by the Human Resources Department. You will authorize the Payroll Department to deduct the Employee Contribution from your pay check. You will be automatically enrolled in the Section 125 Premium Conversion Plan, which allows you to pay the Employee Contribution with pre-tax dollars, unless you elect not to participate.

ELIGIBLE DEPENDENTS
Eligible Dependents include:
1. Spouse (as recognized by the state of Alabama).
2. Child up to age 26 (married or unmarried).
3. Unmarried Disabled child of any age provided the Disability started prior to age 26. Coverage under the Plan continues without interruption for the duration of the Disability as long as the Employee maintains Dependent Coverage.

The term Child may include the following when Required Documents are filed:
1. Natural-born or legally adopted child, including a legally adopted child living with you as the adopting parent during a period of probation.
2. Stepchild.
3. Child who permanently resides in your home and over whom you have legal guardian status by court appointment.
4. Child for whom you are legally required to provide health insurance coverage during the period specified in a Qualified Medical Child Support Order (QMCSO).

A grandchild may only be covered if legally adopted and living in the employee’s home.

REQUIRED DOCUMENTATION
Evidence of dependent eligibility must be submitted within 30 days of enrollment and when requested by the Human Resources Department. The Plan may conduct an audit of dependent eligibility, and the Human Resources Department may request Required Documentation to verify dependent status eligibility. Failure to provide the Required Documentation within 30 days from the request will be deemed fraud or intentional misrepresentation of a material fact and may result in retroactive termination of coverage and liability for benefits paid by the Plan. See the table of Required Documentation for acceptable dependent eligibility documentation.
### USA Health & Dental Plan – Required Documentation

<table>
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<th>Dependent Type</th>
<th>Required Documents</th>
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| **Legal spouse** | - Marriage Certificate
  AND one of the following documents to show current marriage:
  - Most recent federal income tax return as filed with the IRS listing the spouse
  - Current mortgage statement, loan or lease agreement listing both member and spouse
  - Current property tax documents listing both member and spouse
  - Vehicle registration currently in effect listing both member and spouse
  - Current credit card or bank account statement listing both member and spouse
  - Current utility bill listing member and spouse
  
  Note: “Current” is defined as within the last six months. |
| **Separated spouse** | - Court document signed by judge showing legal separation |
| **Common law spouse – NOT ELIGIBLE ON AND AFTER 1/1/2017** | **Common law spouse status prior to 1/1/2017 – Each of the following:**
  - Questionnaire and affidavits provided by Human Resources Department
  - Most recent federal income tax return as filed with the IRS listing the spouse
  - One of the documents listed in the spouse category above as proof of current marriage |
| **Biological child under age 26** | - Birth certificate issued by a state, county or vital records office |
| **Stepchild under age 26** | **Each of the following:**
  - Marriage certificate between member and spouse
  - Birth certificate issued by state, county or vital records office showing spouse as parent
  
  Note: If spouse is not covered by the USA Health & Dental Plan, you will need to provide proof that you and your spouse are currently married. |
| **Adopted child under age 26** | **One of the following documents:**
  - Certificate of adoption or Court Order granting legal custody during a probationary period prior to adoption
  - International adoption papers from country of adoption
  - Birth certificate issued by state, county or vital records office naming the adoptive parents |
| **Child over whom you have legal guardian status** | **One of the following documents:**
  - Placement authorization signed by a judge
  - Final court order signed by a judge |
| **Disabled child of any age who is not married and who became disabled prior to age 26** | **Each of the following:**
  - Acceptable proof of dependent child status
  - Social Security Disability Entitlement Certificate
  - Proof of continuous health insurance coverage for disabled child as the dependent of member since the disability commenced |
| **Grandchild** | A grandchild may only be covered if legally adopted and living in the employee’s home |

All dependents must have a Social Security number to be eligible for coverage. Pursuant to recent federal health care reform, a child under the age of 26 can be married and there are no conditions of residency, student status, or financial dependency.

Assistance with documentation may be obtained from: [www.cdc.gov/nchs/w2w.htm](http://www.cdc.gov/nchs/w2w.htm) (click on your state for details).

Alabama birth, death, marriage or divorce certificate, contact the Health Department: Main Health Center (251) 690-8150.
WHEN COVERAGE BEGINS

Enrollment requires completion of an Application.

If your employment begins on the first day of the calendar month, your coverage will begin on the first day of that month. If your employment begins on a day other than the first day of the calendar month, your coverage will begin on the first day of the month following.

If you fail to make proper Application to the Human Resources Department within 30 days of your first day of employment, you must wait until the Open Enrollment Period to apply for coverage beginning the first of the following Calendar Year.

Eligible Dependents will be covered on the date you become covered, assuming you have filed an Application for Dependent Coverage that has been accepted by the Human Resources Department.

If you enroll during the Open Enrollment Period, normally held in the month of November, coverage will begin on January 1st of the following Calendar Year. Dependent Coverage may also be added during the Open Enrollment Period, to be effective on the first day of the following Calendar Year.

A new Eligible Dependent will be covered on the date they become your dependent if you make Application within 30 days of this Change-In-Status Event. If the new Eligible Dependent is not added within that 30 day period you will be required to wait until the next Open Enrollment Period to add your new Eligible Dependent for coverage effective on the first day of the following Calendar Year.

For Change-In-Status Events other than the addition of a new Eligible Dependent by virtue of marriage, birth, adoption or a QMCSO, coverage is effective the first of the month following approval of the Application. Application must be made during the 30 day Special Enrollment Period (60 days for SCHIP and Medicaid) following the event.

A new employee’s coverage will not begin earlier than the first day on which the employee reports to active employment (first day of work).

WHEN COVERAGE TERMINATES

Coverage under the Plan will end at 12:01 a.m.:

1. The first day of the month following the month in which you cease to be an Employee, or your employment status changes so that you are no longer in a benefits eligible status.

2. The first day of the month for which you fail to make payment of the Employee Contribution.

3. The first day of the month for which a Member fails to make timely payment of the required COBRA premium.

4. The day you enter full-time military service, except as provided by USERRA, as explained in this Member Handbook.

5. Upon discovery of fraud or misrepresentation of a material fact.

6. The day the Plan is terminated or coverage for a class of Members is terminated.

Dependent Coverage will end at 12:01 a.m.:

1. The day the Employee’s coverage terminates.

2. The first day of the month following the date the individual no longer meets the definition of an Eligible Dependent, which includes the:
   a) Date of divorce.
   c) Date your child attains age 26.

3. The first day of the month for which you fail to make payment of the Employee Contribution for Dependent Coverage.

4. When you fail to provide information to verify dependent status within 30 days of receipt of a request for verification from the Human Resources Department or Claims Administrator; in such case, coverage terminates retroactive to the earliest date it is determined the individual ceased to be an Eligible Dependent.

A dependent that loses coverage under the Plan is eligible for COBRA continuation of coverage only if the Human Resources Department is notified in writing within 60 days of the event that caused the individual to no longer meet the definition of an Eligible Dependent. Coverage will terminate retroactively to the first of the month following the event.
If coverage for a spouse is terminated due to divorce, and an Eligible Employee is required by the terms of the divorce judgment to provide health insurance coverage for the divorced spouse, coverage may be provided under this Plan only through COBRA continuation of coverage. The divorced spouse is no longer an Eligible Dependent under this Plan and may continue coverage only through COBRA. If notice to the Human Resources Department is not made within 60 days of the date of divorce, COBRA continuation of coverage will not be available to the divorced spouse.

OPEN ENROLLMENT PERIOD
There is a one-month Open Enrollment Period, usually the month of November, during which an Employee may enroll in the USA Health & Dental Plan and/or add Eligible Dependents. During this period you may file an Application with the Human Resources Department and coverage will begin on the first day of the following Calendar Year.

SPECIAL ENROLLMENT PERIOD DUE TO CHANGE-IN-STATUS EVENT
You may also enroll in the Plan, enroll your Eligible Dependents or terminate coverage for yourself or a dependent when certain events cause a Change-In-Status. To make an enrollment change due to a Change-In-Status Event, you must make Application to the Human Resources Department within 30 days (unless otherwise noted) of the event.

A Change-In-Status Event, which allows you to make changes to your enrollment in the Plan within 30 days (unless otherwise noted), is deemed to have occurred upon:

1. A change in your marital status (marriage, divorce, legal separation or death of the spouse).
2. A change in the number of your dependents (birth or adoption of a child, death of a child, obtaining legal guardianship).
3. A change in your, or your spouse’s, employment status (starting/ending employment, changing from part-time to full-time or vice versa, a strike or lock-out, or taking or returning from an unpaid leave of absence or leave under the Family and Medical Leave Act or USERRA during which your, or your spouse’s, coverage terminated).
4. Exhaustion of your coverage period under a previous employer’s COBRA continuation.
5. A significant change in the cost of or coverage provided by your spouse’s employer-sponsored health plan, or a significant change in the cost of or coverage provided by this Plan.
6. A change in the eligibility status of a dependent child (child reaching the maximum age for coverage under the Plan).
7. An end to the Disability of a Disabled child enrolled as your dependent under the Plan.
8. A change in your residence or work site, or that of a spouse or dependent, which affects ability to access benefits under this or another employer-sponsored health plan.
9. A change required by a court order.
10. You or your dependent becoming entitled to Medicare or Medicaid.
11. You or your dependent(s) loss of coverage under Medicaid or a State Children’s Health Insurance Plan (SCHIP) because of loss of eligibility. An enrollment request must be made within 60 days of the termination of coverage.
12. You or your dependent(s) becomes eligible for the premium assistance under Medicaid or SCHIP. An enrollment request must be made within 60 days of becoming eligible for the premium assistance.

The change in coverage must be consistent with the Change-In-Status Event, and you must provide written documentation, upon request, to verify the Change-In-Status Event.

DUPLICATE COVERAGE EXCLUDED
If both you and your spouse are eligible for the USA Health & Dental Plan as Employees:

1) Both Employees may elect single coverage.
2) One Employee may elect Dependent Coverage and the spouse may be covered as an Eligible Dependent.

Under no circumstances may both Employees elect Dependent Coverage or an Employee be covered as both an Eligible Employee and Eligible Dependent.
CONTINUATION WHILE ON APPROVED LEAVE

An Eligible Employee will continue to be eligible for coverage while in a paid status on payroll during a period of Paid Time Off (PTO), paid sick, vacation or personal leave, or while on unpaid Family and Medical Leave or Uniformed Services Leave, provided the Eligible Employee has qualified for such leave and complied with the leave requirements, including payment of the Employee Contribution.

An Eligible Employee will continue to be eligible for coverage while on unpaid personal leave. The monthly premium required for continued coverage is the applicable funding rate (COBRA rate) with no Employer Contribution.

Failure to pay the required Employee Contribution within 30 days of the first day of the month for which the contribution is due will result in termination of coverage, and coverage may be reinstated only when the Employee returns to a paid status and pays any Employee Contributions due, subject to all Plan provisions and limitations.

SURVIVING DEPENDENT BENEFIT

The Eligible Dependents of an Employee covered under the Plan at the time of the Employee’s death may continue coverage under the Plan. The Eligible Dependents must request coverage under this Surviving Dependent benefit within 60 days of the date coverage terminates by making Application to the Human Resources Department.

The monthly premium required for coverage is the funding rate with no Employer Contribution.

This benefit is available only if the surviving dependents are not eligible for enrollment in any other group health plan, including that provided by a surviving dependent’s employer, or Medicare.

If the Eligible Dependents of a deceased Employee are not eligible for continuation of coverage under this Surviving Dependent benefit, coverage may be continued under COBRA.

Coverage may be continued until the earlier of:
1. The first day of the month for which the monthly premium is not paid within the 30-day grace period.
2. The first day of the month following the date on which the Surviving Dependent no longer meets the definition of an Eligible Dependent.
3. All dependents, the first of the month following the date the surviving spouse remarries.
4. All dependents, the first of the month following the date the surviving spouse becomes eligible for other group health coverage.
5. All dependents, the first of the month following the date the surviving spouse becomes eligible for Medicare.
6. The date the Plan is amended to terminate the Surviving Dependent health benefit, or the date the Plan is terminated.

Extended coverage provided under this Surviving Dependent benefit will run concurrent with COBRA. When a dependent’s coverage is terminated for one of the reasons listed, the dependent may be eligible to elect COBRA continuation of coverage for any months remaining under COBRA.

LEGAL PROTECTION FOR CONTINUATION OF COVERAGE

There are conditions under which a Member’s health and dental benefits may be continued beyond the date coverage would otherwise terminate. Refer to the sections in this Member Handbook concerning COBRA continuation of coverage, Family and Medical Leave (FMLA) and Uniformed Services Leave (USERRA) for circumstances that allow for a limited continuation of a Member’s coverage.

RESCISSION OF COVERAGE

As permitted by the Affordable Care Act, the Plan reserves the right to rescind coverage. A rescission of coverage is a retroactive termination of coverage due to fraud or intentional misrepresentation of material fact. A termination of coverage is not a rescission if it has only a prospective affect or it is attributable to non-payment of contributions.
ACTIVE EMPLOYEES ELIGIBLE FOR MEDICARE

It is very important that the Employee or Member notify the Human Resources Department if eligible for Medicare Part A coverage. The University is required to make disclosure to the Centers for Medicare and Medicaid Services of all members who have Medicare coverage.

If you continue as an Employee when you are age 65 or older, or are otherwise eligible for Medicare, you and your Eligible Dependent(s) will continue to be covered under the same eligibility rules and for the same benefits available to Employees under age 65.

This Plan will be primary over Medicare and will provide benefits first. Medicare will then pay for Medicare eligible expenses, if any, not paid by this Plan. This rule applies to Eligible Employees eligible for Medicare and any Eligible Dependents who are eligible for Medicare.

There is one exception to this policy: If an Eligible Employee or Eligible Dependent becomes eligible for Medicare benefits based solely on End Stage Renal Disease (ESRD), this Plan will be primary for the first 30 months of eligibility for Medicare. After the first 30 months of eligibility for Medicare, if the Eligible Employee or Eligible Dependent is still eligible for Medicare due to ESRD or for any other reason, Medicare will be primary.

Employees and/or their Eligible Dependents may enroll in Medicare Parts A (hospitalization) and B (physician services) at the time they become eligible for Medicare. If you are eligible, you should enroll in Medicare Part A, which is premium-free. There are also some advantages of enrolling in Medicare Part B when you are eligible.

You may enroll in Medicare Part D (prescription drugs) if you are eligible for Medicare.

If you do not enroll in Medicare Part B or Medicare Part D when you are initially eligible, you can enroll in Part B or Part D during Medicare’s Special Enrollment Period, which begins the month your employment ends or the month you are no longer covered under the Plan as an active employee, whichever is later. Be sure to enroll right away because Social Security charges a late enrollment penalty if you fail to enroll during the Special Enrollment Period.

TERMINATION AND REINSTATEMENT

Employees and/or their Eligible Dependents who have been covered under the Plan, and have had their coverage terminate for one of the reasons listed previously, will be eligible for reinstatement of coverage under certain conditions, such as re-employment or enrollment during the Open Enrollment or Special Enrollment Periods.

RETIREE HEALTH PLAN

Public Education Employees Health Insurance Plan (PEEHIP)

The University of South Alabama participates in PEEHIP for its qualified retired employees of the Teachers’ Retirement System. At retirement, you may apply to continue your health coverage for yourself and eligible dependents. You may continue coverage to Medicare eligibility and then you may continue under the Medicare supplemental coverage. You may obtain additional information from the Human Resources Department or online at:


The University of South Alabama makes a significant contribution towards the cost of your PEEHIP Health coverage after your retirement under the Teachers’ Retirement System if you elect to continue coverage.

USA HealthCare Management, LLC does not participate in the retiree extended coverage and coverage terminates for these employees at termination of employment with the COBRA continuation.

FREEDOM OF CHOICE

The USA Health & Dental Plan offers benefits designed to provide you with freedom of choice when selecting medical providers and you do not need a referral to see a specialist.

Blue Cross Blue Shield manages a network of medical providers to ensure the best medical care at a reasonable cost. Negotiated savings are passed on to you through increased benefits when you use a provider who is a member of this network.

When medical care is needed, you may elect to use any medical provider. The benefits you receive may depend on the provider classification and the type of medical service. Provider classifications include:

- **USA Health**
- **Blue Cross Blue Shield In-Network** (Sometimes referred to as Other PPO)
- **BlueCard® Program**
- **Out-of-Network or Non-PPO Provider**

**USA HEALTH**

**USA Health**, a network of hospitals, physicians and other medical providers and services offers the best benefits available under the Plan.

- There is no hospital admission deductible.
- There is no outpatient facility copay.
- The office visit copay is only $10.

**PHYSICIAN REFERRAL LINE**

(251) 434-3711

USA Health –

USA Medical Center
USA Physicians Group
USA College of Medicine
USA Mitchell Cancer Institute
USA Children’s & Women’s Hospital

**BLUE CROSS BLUE SHIELD IN-NETWORK** – Network providers include a hospital, physician, pharmacy or other medical provider that contracts with Blue Cross Blue Shield.

Outside Alabama, Blue Cross Blue Shield Providers are members of the BlueCard PPO network. All Blue Cross Blue Shield affiliated medical providers are referred to as In-Network or Other PPO.

**USA HEALTH** – A hospital, physician or other medical provider affiliated with the University of South Alabama. These services are provided at the lowest cost to you. The higher level of benefits available through USA Health does not apply when you use any other provider, regardless of the situation and regardless of whether or not the service is available from a USA Health Provider.

**BLUECARD® PROGRAM** – A network of providers affiliated with Blue Cross Blue Shield, in every state in the United States and in many international countries. If you seek medical attention outside Alabama, you may locate a BlueCard PPO member by calling the toll-free number on the back of your ID card. You can contact BlueCard PPO provider at 1-800-810-2583 or [http://provider.bcbs.com](http://provider.bcbs.com).

**PHARMACY NETWORK** – Express Scripts, Inc. also has an extensive network of pharmacies.

**OUT-OF-NETWORK or NON-PPO** – Services that are **not** rendered by or received from a Network Provider are subject to a reduced level of benefits, and some services are not covered unless received from a Network Provider.

**PROVIDER IDENTIFICATION**

Network providers can be identified by contacting the specific provider or contacting customer service.

**MEDICAL** providers may be identified at –

[www.bcbsal.com](http://www.bcbsal.com) or [www.AlabamaBlue.com](http://www.AlabamaBlue.com)

[www.usahealthsystem.com/physiciandirectory](http://www.usahealthsystem.com/physiciandirectory)

**PHARMACY** providers may be identified at –

[www.express-scripts.com/activate](http://www.express-scripts.com/activate)
COST SHARING

The cost of medical care is shared with the USA Health & Dental Plan paying most of the expense. The member is subject to payment requirements. The requirements are summarized in the table titled Benefit Summary. The following will help you understand some of the terms used to describe your portion of the medical expense.

**Admission Deductible:** Paid upon admission to a hospital. Only one deductible is required when two or more family members have hospital expenses resulting from injuries received in one accident.

**Copay or copayment:** A fixed dollar amount paid for specific services on receipt of care. The most common example is the office visit copay.

**Coinsurance:** The amount that you must pay as a percent of the allowed amount under the Major Medical Benefit which is limited by the annual out-of-pocket maximum.

**Excess of Allowed Amount or Allowance:** The Claims Administrator determines the value of services and expenses based on network provider contracts. The allowed amount may be significantly less than the actual charge. Network providers do not bill for any excess over the Allowed Amount. Non-Network or Out-of-Network providers may bill for the excess. The Member is responsible for the amount billed in excess of the Allowed Amount or Allowance.

**Out-of-Area Services:**

Typically, when accessing care outside the Blue Cross Blue Shield of Alabama service area, you will obtain care from healthcare providers that have a contractual agreement with Blue Cross Blue Shield in that geographic area. The BlueCard® Program will assist with obtaining services from a Blue Cross Blue Shield In-Network provider.

**Out-of-Network or Non-PPO:**

Some services are not covered when rendered by an Out-of-Network or Non-PPO provider. Some services may only be covered in the case of emergency care or for accidental injury. Other services may require a higher copay or coinsurance amount for the Out-of-Network or Non-PPO provider. These conditions are summarized in the Benefit Summary table.

**Calendar Year Deductible or Deductible**

The amount each member must pay for some medical expenses before the Plan starts to pay the Major Medical percentage. Only one calendar year deductible is required when two or more family members have expenses resulting from injuries received in one accident.

**Pharmacy Copay and Copayment**

The pharmacy benefit has a fixed copay amount per 30 day supply and a home delivery program that charges only 2 copays for a 90 day supply.

**Calendar Year Out-of-Pocket Maximum**

The Major Medical coinsurance for covered health services received by a network provider are limited by the out-of-pocket maximum. There is an annual out-of-pocket maximum per member (no family maximum). When the calendar year deductible plus the out-of-pocket maximum are reached, the coinsurance percentage increases from 80% to 100% for the remainder of that calendar year. Not all expenses apply to the out-of-pocket maximum including but not limited to:

- out-of-network services or supplies;
- calendar year deductible;
- hospital admission deductible;
- copayments and copays;
- non-covered services;
- amounts in excess of plan limits, the allowed amount or allowance;
- any penalty such as for failure to pre-certify;
- services or supplies with limited coverage or not covered by the Plan.

The Base Plan’s out-of-pocket maximum is based on Grandfathered Plan status under the Affordable Care Act and does not include all essential health services and does not aggregate all costs towards the out-of-pocket maximum.

**Out-of-Country Coverage**

Covered medical treatment rendered outside of the United States when medically necessary will be covered by the Plan. Claims must be filed, in U.S. dollars, with the Claims Administrator. Only medical treatment for which the individual would be charged regardless of health insurance coverage will be considered a covered expense.
USA HEALTH & DENTAL PLAN – BASE PLAN – BENEFIT SUMMARY

PRESCRIPTION DRUG BENEFIT ADMINISTERED BY EXPRESS SCRIPTS, INC. (ESI)

ESI administers the pharmacy benefit. ESI has an extensive network of pharmacies which will accept this coverage. You must present your ESI identification card to the pharmacy at the time you fill your prescription. You should also show your ESI identification card at your physician’s office.

ESI offers a voluntary home delivery program for some maintenance drugs which can save you one copay. Home delivery can provide a 90 day supply of some maintenance drugs and you pay only 2 copays for that 90 day supply.

All drugs must be FDA approved legend drugs prescribed by a physician and dispensed by a licensed pharmacist. Prescription drug benefits are provided for participating pharmacies only. A participating pharmacy is a pharmacy in contract with Express Scripts. Some prescriptions require prior authorization and specialty medications may be restricted to purchase from Accredo pharmacy.

PRESCRIPTION DRUG BENEFIT

Prescription Drug Card:

Non-Maintenance Prescriptions
up to a 30 day supply at retail.

Maintenance Prescriptions
up to a 90 day supply; one copay for each 30 day supply.

Home Delivery requires only two copays for a 90 day supply.

Specialty Drug refills are limited to the first two after which they must be purchased from ESI Specialty Pharmacy Accredo or the individual must pay 100% of the cost.

Benefits are not provided for fertility drugs.

Express Scripts Participating Pharmacy Network:

Separate $50 prescription drug deductible per member per calendar year; maximum of 3 per family. Each prescription purchased from a Participating Pharmacy will be covered at 100% after the deductible with the following copays:

TIER & TYPE: COPAY PER 30 DAY SUPPLY

1 Generic $10.00
2 Preferred Brand Name $30.00
3 Non-Preferred Brand Name $50.00
4 Specialty $100.00

Contraceptives are covered at 100% for all FDA approved contraceptives prescribed by a physician.

Non-Participating Pharmacy:

Not covered.

No benefits for prescriptions purchased at a non-Participating Pharmacy.

Home Delivery – Save 1 copay for a 90 day supply – Optional (not required)

- Some maintenance drugs may be delivered direct to your home and you pay only 2 copays for a 90 day supply with no shipping fee.
- You will need to complete a home delivery order form and get a 90 day prescription from your doctor plus refills for up to one year.
- You may also have your doctor ePrescribe or fax your prescription.
- Additional information may be obtained at 1-800-698-3757 or Express-Scripts.com.

Diabetic Supplies

- Diabetic testing supplies including blood glucose test strips, lancets, and meters are covered at 100% with no deductible or copay.
- Injectable and oral diabetic medications will require a copay and are subject to the deductible.
- Insulin, needles, and syringes purchased on the same day will have one copay; otherwise each has a separate copay.

Vaccination

- Some vaccinations are available at your network pharmacy with no copay.
- Find out if your pharmacist can administer recommended vaccinations.
- Present your Express Scripts identification card to the pharmacist at the time of service.
- Additional information about covered vaccines can be obtained at vaccines.gov or cdc.gov/vaccines.

ALWAYS SHOW YOUR EXPRESS SCRIPTS IDENTIFICATION CARD TO YOUR PHYSICIAN AND PHARMACY
**Prior Authorization:** Some medications are not covered unless you first receive approval through a coverage review (prior authorization). This review uses plan rules based on FDA-approved prescribing and safety information, clinical guidelines and uses that are considered reasonable, safe and effective. There are medications that may be covered, but with limits (for example, only for a certain amount or for certain uses), unless you receive approval through a coverage review. During this review, Express Scripts asks your doctor for more information than what is on the prescription before the medication may be covered under the Plan. To find out whether a medication requires a coverage review, you may sign into [express-scripts.com](http://express-scripts.com) and select “Price a Medication” from the drop-down menu under “Manage Prescriptions.” After looking up the medication’s name, click “View coverage notes” to see coverage details.

**My Rx Choices:** An easy way to lower your out-of-pocket prescription costs. Your My Rx Choices prescription savings program is designed to help you find potential savings on prescription medications that you or your covered family members take on an ongoing basis. Your doctor knows which medications are right for you but may not know their cost. My Rx Choices provides you with available lower-cost options so that you and your doctor can make the most informed decisions based on health and cost. No prescription is ever changed without your doctor’s approval. Simply log in to [Express-Scripts.com](http://Express-Scripts.com) or contact 1-855-687-3857 for additional information.

**Specialty Medications:** Specialty medications are drugs that are used to treat complex conditions, such as cancer, growth hormone deficiency, hemophilia, hepatitis C, immune deficiency, multiple sclerosis and rheumatoid arthritis. Specialty drug refills are limited to not more than two before they must be purchased from the ESI Specialty Pharmacy Network (Accredo) or the individual must pay 100% of the cost. Accredo, an Express Scripts specialty pharmacy, is composed of therapy-specific teams that provide an enhanced level of individual service to patients with special therapy needs. Specialty drugs require an enhanced level of service which can be received by ordering specialty medications through Accredo. Specialized services include:

- Toll-free access to specialty-trained pharmacists and nurses 24 hours a day, 7 days a week;
- Delivery of your medications within the United States, on a scheduled day, Monday through Friday, at no additional charge;
- Most supplies, such as needles and syringes, provided with your medications;
- Safety checks to help prevent drug interactions.

**Step Therapy:** Step therapy is a program for maintenance drugs to treat ongoing medical conditions such as arthritis, heartburn, diabetes, and high blood pressure. The program provides safe and effective treatments for your good health based on the most cost effective medications. Your doctor participates in this program to ensure the best results. Step therapy may require that the treatment start with generic drugs and then may advance to specific brand-name drugs based on the medical condition and prior authorization.

**Generic Substitution:** The copay for a brand name drug includes the difference in cost between the brand drug and generic substitution when there is a generic available and the prescription does not specifically state “dispense as written.” The additional copay amount is limited to not more than $100 per 30 day supply.

**Refills:** Refills of prescriptions are allowed only after 75% of the allowed amount of the previous prescription has been used; example 23 days in a 30 day supply. Call customer service at the phone number listed on the back of your identification card if you need an early refill.

**Direct Filing:** Almost all pharmacy claims will be electronically filed with Express Scripts by the pharmacy. Should you need to file a claim direct, you may send the prescription receipt with your identification information (copy of identification card) to –

Express Scripts – P.O. Box 66568 – St Louis, MO 63166-6568

**Prescription Management:** Quantity limits, prior authorization, step therapy, exclusions and mandatory generic utilization are all programs designed to ensure good health while reducing cost. Prescription management is based on limits recommended by the Food and Drug Administration, manufacturer of the drug and peer review medical literature as well as ESI’s medical management team.

Additional information is listed in the Benefit Exclusions section of this booklet.
## MEDICAL AND DENTAL BENEFITS ADMINISTERED BY BLUE CROSS BLUE SHIELD

### TYPES OF PROVIDERS & BENEFIT DIFFERENCES

**IN-NETWORK:** Includes all USA Health hospitals, physicians and clinics. USA Health Providers have the highest benefit level. When you use a USA Health Provider you will pay less. Also included are “Other PPO” providers. Other PPO providers include facilities, physicians and providers which are under contract with BCBS but are not USA Health Providers which have a slightly higher cost to you. You can locate in-network providers at www.AlabamaBlue.com.

**OUT-OF-NETWORK:** Also referred to as Non-PPO Providers, have the lowest benefit and cost you the most.

**ALLOWED AMOUNT OR ALLOWANCE:** Benefit payments are based on the amount of the provider’s charge that BCBS recognizes for payment of benefits. The “allowed amount” or “allowance” is determined solely by the Claims Administrator for medical services rendered by both In-Network and Out-of-Network providers. You are responsible for the provider’s charges over the allowed amount or allowance when you receive services Out-of-Network.

### INPATIENT HOSPITAL FACILITY SERVICES

<table>
<thead>
<tr>
<th>BENEFIT</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Facility Coverage (Including Maternity)</td>
<td>USA Health: Covered at 100% of the allowance with no deductible or copay. Other PPO: Covered at 100% of the allowance after $750 per admission deductible and $100 copay per day for days 2 through 5.</td>
<td>Covered at 100% of the allowance after $750 per admission deductible and $100 copay per day for days 2 through 5. Out-of-Network coverage available only for medical emergency or accidental injury; otherwise, not covered.</td>
</tr>
<tr>
<td>Excess Over 365 Days of Care</td>
<td>80% of the allowed amount, subject to the calendar year deductible.</td>
<td></td>
</tr>
<tr>
<td>Preadmission Certification Required for Coverage</td>
<td>All hospital admissions (general hospitals and psychiatric specialty hospitals) require preadmission certification, except medical emergency and maternity. Emergency admissions require certification within 48 hours of admission. Generally, if precertification is not obtained, no benefits will be payable for the hospital admission or services of the admitting physician. Failure to obtain precertification requires a $400 penalty. Assistance with precertification of a hospital admission can be obtained by calling 1-800-248-2342.</td>
<td></td>
</tr>
</tbody>
</table>

**Note:** In Alabama, inpatient hospital benefits are paid only if received from a BCBS provider. Outside Alabama inpatient hospital benefits are paid only if received from a BlueCard PPO provider, except in cases of medical emergency or accidental injury. In cases of Emergency Admission, the admission deductible and daily copay are waived for all non-USA hospitals except in the City of Mobile. The member must be admitted through the emergency room, requiring immediate medical intervention as a result of a severe, life threatening or potentially disabling condition.

### OUTPATIENT HOSPITAL FACILITY SERVICES

<table>
<thead>
<tr>
<th>BENEFIT</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery Including ambulatory surgical centers</td>
<td>USA Health: Covered at 100% of the allowance. No facility copay. Other PPO: Covered at 100% of the allowance after a $250 facility copay.</td>
<td>Non-PPO Provider Outside Alabama: Not covered unless due to medical emergency or accidental injury and then, same as in-network Other PPO Physician Non-PPO Provider In Alabama: Not covered.</td>
</tr>
<tr>
<td>CyberKnife Treatment</td>
<td>USA Mitchell Cancer Institute: Covered at 100% of the allowance. No facility copay. Other PPO: Not covered.</td>
<td>Not covered.</td>
</tr>
<tr>
<td>Medical Emergency – Emergency Room</td>
<td>USA Health: Covered at 100% of the allowance after a $25 copay. Other PPO: Covered at 100% of the allowance after a $250 facility copay. *</td>
<td>Not covered unless services are due to an accidental injury or medical emergency. Non-PPO Provider Outside Alabama: Covered at 100% of the allowance after a $250 facility copay. Non-PPO Provider In Alabama: Covered at 100% of the allowance after a $250 facility copay only when due to medical emergency; otherwise, not covered.</td>
</tr>
</tbody>
</table>

* Copay waived if admitted within 24 hours.
<table>
<thead>
<tr>
<th>Benefit</th>
<th>In-Network</th>
<th>Out-Of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Accidental Injury</strong></td>
<td><strong>USA Health</strong>: Covered at 100% of the allowance with no deductible or copay.</td>
<td>Covered at 100% of the allowance with no deductible or copay within 72 hours of the accident; after 72 hours covered at 80% of the allowance, after the calendar year deductible; otherwise, not covered.</td>
</tr>
<tr>
<td></td>
<td><strong>Other PPO</strong>: Covered at 100% of the allowance with no deductible or copay.</td>
<td></td>
</tr>
<tr>
<td><strong>Diagnostic Imaging</strong></td>
<td><strong>USA Health</strong>: Covered at 100% of the allowance with no deductible or copay.</td>
<td>Not covered except for medical emergency or accidental injury, then covered at 100% of the allowance after a $50 facility copay.</td>
</tr>
<tr>
<td>X-Ray, CAT Scan, MRI, PET, ERCP, angiography, arteriography, colonoscopy, UGI endoscopy, etc.</td>
<td><strong>Other PPO</strong>: Covered at 100% of the allowance after a $50 facility copay.</td>
<td></td>
</tr>
<tr>
<td><strong>Diagnostic Lab and Pathology</strong></td>
<td><strong>USA Health</strong>: Covered at 100% of the allowance with no deductible or copay.</td>
<td>Not covered except for medical emergency or accidental injury, then covered at 100% of the allowance with no deductible or copay.</td>
</tr>
<tr>
<td></td>
<td><strong>Other PPO</strong>: Covered at 100% of the allowance with no deductible or copay.</td>
<td></td>
</tr>
<tr>
<td><strong>Hemodialysis, IV Therapy</strong></td>
<td><strong>USA Health</strong>: Covered at 100% of the allowance with no deductible or copay.</td>
<td>Not covered.</td>
</tr>
<tr>
<td>Chemotherapy and Radiation Therapy</td>
<td><strong>Other PPO</strong>: Covered at 100% of the allowance after a $25 facility copay.</td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient hospital services or supplies not listed as a Covered Service</strong></td>
<td>Covered at 80% of the allowance subject to the calendar year deductible.</td>
<td>Covered at 80% of the allowance subject to the calendar year deductible.</td>
</tr>
<tr>
<td><strong>Optical Endomicroscopy</strong></td>
<td><strong>USA Health</strong>: Covered at 100% of the allowance with no deductible or copay.</td>
<td>Not covered.</td>
</tr>
<tr>
<td>Physician and anesthesia services are billed separately and paid at 100% of the allowance</td>
<td><strong>Other PPO</strong>: Covered at 100% of the allowance after a $250 facility copay.</td>
<td></td>
</tr>
<tr>
<td><strong>Note</strong>: Outpatient benefits for Non-PPO hospitals in Alabama are available only in cases of medical emergency or accidental injury.</td>
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<td></td>
</tr>
</tbody>
</table>

**PHYSICIAN SERVICES**

<table>
<thead>
<tr>
<th>Benefit</th>
<th>In-Network</th>
<th>Out-Of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Office Visits and Consultations</strong></td>
<td><strong>USA Health</strong>: Covered at 100% of the allowance after a $10 office visit copay.</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Other PPO</strong>: Covered at 100% of the allowance after a $30 office visit copay.</td>
<td></td>
</tr>
<tr>
<td><strong>Emergency Room Physician</strong></td>
<td><strong>USA Health</strong>: Covered at 100% of the allowance after a $10 office visit copay.</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Other PPO</strong>: Covered at 100% of the allowance after a $30 office visit copay.</td>
<td></td>
</tr>
<tr>
<td><strong>Surgery &amp; Anesthesia</strong></td>
<td><strong>USA Health</strong>: Covered at 100% of the allowance.</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Other PPO</strong>: Covered at 100% of the allowance.</td>
<td></td>
</tr>
<tr>
<td><strong>Inpatient Visits</strong></td>
<td><strong>USA Health</strong>: Covered at 100% of the allowance.</td>
<td></td>
</tr>
<tr>
<td><strong>Inpatient Consultations</strong></td>
<td><strong>Other PPO</strong>: Covered at 100% of the allowance.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Limited to one (1) consultation per specialist per confinement.</td>
<td></td>
</tr>
<tr>
<td><strong>Maternity</strong></td>
<td><strong>USA Health</strong>: Covered at 100% of the allowance.</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Other PPO</strong>: Covered at 100% of the allowance.</td>
<td></td>
</tr>
<tr>
<td><strong>Diagnostic Laboratory, X-rays, and Pathology</strong></td>
<td><strong>USA Health</strong>: Covered at 100% of the allowance.</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Other PPO</strong>: Covered at 100% of the allowance.</td>
<td></td>
</tr>
</tbody>
</table>

**Non-PPO Provider Outside Alabama**: Covered at 80% of the allowance, after calendar year deductible.  
**Non-PPO Provider In Alabama**: Covered same as in-network Other PPO Physician only for medical emergency or accidental injury; otherwise, not covered.
### Bariatric Surgery
(Surgeon, Assistant Surgeon & Anesthesia)
Limited to 1 procedure per member per lifetime.

<table>
<thead>
<tr>
<th>USA Health</th>
<th>Covered at 100% of the allowance.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other PPO</td>
<td>Covered at 100% of the allowance.</td>
</tr>
</tbody>
</table>

Bariatric Services in Alabama must be performed by a BCBS Bariatric Surgery Network Provider.

Not covered.

### Second Surgical Opinion

<table>
<thead>
<tr>
<th>USA Health</th>
<th>Covered at 100% of the allowance.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other PPO</td>
<td>Covered at 100% of the allowance.</td>
</tr>
</tbody>
</table>

Not covered.

### Chemotherapy and Radiation Therapy

<table>
<thead>
<tr>
<th>USA Health</th>
<th>Covered at 100% of the allowance.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other PPO</td>
<td>Covered at 100% of the allowance.</td>
</tr>
</tbody>
</table>

Covered at 80% of the allowed amount, after the calendar year deductible.

### TMJ Phase I Treatment

<table>
<thead>
<tr>
<th>USA Health</th>
<th>Covered at 100% of the allowance after a $10 office visit copay.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other PPO</td>
<td>Covered at 100% of the allowance after a $30 office visit copay.</td>
</tr>
</tbody>
</table>

Non-PPO Provider Outside Alabama: Covered at 100% of the allowance after a $30 office visit copay.

Non-PPO Provider In Alabama: Not covered.

### Allergy Testing and Treatment

<table>
<thead>
<tr>
<th>USA Health</th>
<th>Covered at 100% of the allowance after a $10 office visit copay.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other PPO</td>
<td>Covered at 80% of the allowance after the calendar year deductible.</td>
</tr>
</tbody>
</table>

Not covered.

**Note:** In Alabama, physician benefits are available only in cases of medical emergency or accidental injury. Some outpatient services require precertification and are listed at [AlabamaBlue.com/precert](http://AlabamaBlue.com/precert).

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### SKILLED NURSING FACILITY

<table>
<thead>
<tr>
<th>BENEFIT</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility charges when medically necessary and precertified, call – 1-800-821-7321</td>
<td>Covered at 100% of the allowance with no deductible or copay. Maximum benefit 60 days of coverage per calendar year.</td>
<td></td>
</tr>
</tbody>
</table>

Precertification of the facility stay must be pre-approved for coverage by the Claims Administrator. Skilled nursing facility services are covered when admission is within 14 days after the patient leaves the hospital and that hospital stay was for at least three consecutive days for the same illness or injury. The patient’s doctor must visit at least once every 30 days and visits must be written in the patient’s medical record. The facility must be an approved skilled nursing facility as defined by the Social Security Act. Precertification required – call 1-800-821-7321.

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### MAJOR MEDICAL BENEFIT

Most of the significant medical services are paid at 100% with or without a copay or deductible. Other covered services are subject to a calendar year deductible and then the Plan pays 80% of the allowed amount up to the annual out-of-pocket maximum. The out-of-pocket maximum is intended to help the participant with major expenses. The member pays 20% of the first $6,000 and then the benefit percentage increases to 100% for the remainder of the calendar year. Copays, deductibles, coinsurance, the excess over the allowed amount or benefit limitations and amounts not covered by the Plan (exclusions) do not apply to the out-of-pocket maximum.

**Calendar Year Deductible**

$400 per member each calendar year; no family maximum.

**Annual Out-of-Pocket Maximum – Plan pays 100% for the remainder of the calendar year.**

$1,200 per individual plus the $400 calendar year deductible for a total of $1,600.

Other Covered Services are the only expenses applicable to the out-of-pocket maximum.

There is no out-of-pocket maximum.

The Base Plan is considered to be a grandfathered plan under the Affordable Care Act and as such not subject to all of the ACA’s provisions. The inpatient deductible, inpatient per day copay, outpatient facility copay, non-covered services, prescription drug copays, fixed per visit copays, all mental health and substance abuse services and out-of-network services do not apply toward the member’s out-of-pocket maximum.
<table>
<thead>
<tr>
<th>OTHER COVERED SERVICES</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Chiropractic Services</strong>&lt;br&gt;Services of a Chiropractor practicing within the scope of the license, limited to 60 treatments each calendar year</td>
<td>Covered at 80% of the allowance, after the calendar year deductible.</td>
<td><strong>Non-PPO Provider Outside Alabama:</strong> Covered at 80% of the allowance, after the calendar year deductible.&lt;br&gt;<strong>Non-PPO Provider In Alabama:</strong> Not covered.</td>
</tr>
<tr>
<td><strong>Rehabilitative Occupational, Physical and Speech Therapy</strong>&lt;br&gt;Limited to 60 visits per member each calendar year</td>
<td><strong>USA Health:</strong> Covered at 100% of the allowance, after the $10 office visit copay if charged.&lt;br&gt;<strong>Other PPO:</strong> Covered at 80% of the allowance, after the calendar year deductible.</td>
<td>Covered at 80% of the allowance, after the calendar year deductible.</td>
</tr>
<tr>
<td><strong>Habilitative Occupational, Physical and Speech Therapy</strong>&lt;br&gt;Limited to 60 visits per member each calendar year</td>
<td><strong>USA Health:</strong> Covered at 100% of the allowance, after the $10 office visit copay if charged.&lt;br&gt;<strong>Other PPO:</strong> Covered at 80% of the allowance, after the calendar year deductible.</td>
<td>Covered at 80% of the allowance, after the calendar year deductible.</td>
</tr>
<tr>
<td><strong>Durable Medical Equipment</strong>&lt;br&gt;Orthotic devices are limited to a maximum benefit of two pair every 12 consecutive months</td>
<td>Covered at 100% of the allowance, no deductible. Allowed amount is the smaller of the rental or purchase price.</td>
<td>Not covered.</td>
</tr>
<tr>
<td><strong>Home Health</strong>&lt;br&gt;Requires Precertification&lt;br&gt;Call 1-800-821-7231</td>
<td>Covered at 100% of the allowance with no deductible for services rendered by a Participating Home Health Agency in Alabama.</td>
<td>Not covered.</td>
</tr>
<tr>
<td><strong>Hospice</strong>&lt;br&gt;Limited to 180 days lifetime maximum</td>
<td>Covered at 100% of the allowance with no deductible.&lt;br&gt;<strong>Requires Precertification Call 1-800-821-7231</strong></td>
<td>Not covered.</td>
</tr>
<tr>
<td><strong>Ambulance Services</strong></td>
<td>Covered at 80% of the allowance, after the calendar year deductible.</td>
<td>Not covered.</td>
</tr>
<tr>
<td><strong>Allergy Testing</strong></td>
<td><strong>USA Health:</strong> Covered at 100% of the allowance, after a $10 copay.&lt;br&gt;<strong>Other PPO:</strong> Covered at 80% of the allowance, after the calendar year deductible.</td>
<td>Not covered.</td>
</tr>
<tr>
<td><strong>Allergy Treatment</strong></td>
<td>Covered at 80% of the allowance, after the calendar year deductible.</td>
<td>Not covered.</td>
</tr>
<tr>
<td><strong>Orthodontic and periodontic services required after orthognathic surgery</strong></td>
<td>Covered at 80% of the allowance after the calendar year deductible.</td>
<td>Not covered.</td>
</tr>
<tr>
<td><strong>Eyeglasses and Contact Lenses</strong>&lt;br&gt;Limited to one pair to replace the human lens function as a result of eye surgery if Medically Necessary</td>
<td>Covered at 80% of the allowance, after the calendar year deductible.</td>
<td>Not covered.</td>
</tr>
<tr>
<td><strong>Hearing</strong>&lt;br&gt;Newborn Hearing Test –&lt;br&gt;Audiology related to illness, injury or to correct a speech deficiency</td>
<td>Universal Newborn Hearing Screening covered at 100%, no deductible or copay.&lt;br&gt;Other, covered at 80% of the allowance, after the calendar year deductible.&lt;br&gt;The benefit does not include hearing aids or examinations for prescribing or fitting of hearing aids.</td>
<td>Not covered.</td>
</tr>
<tr>
<td><strong>Removal of Wisdom Teeth (Impacted Unerupted) and related anesthesia</strong>&lt;br&gt;Performed by a doctor of surgery</td>
<td>Covered at 100% of the allowance with no deductible.</td>
<td>Covered at 80% of the allowance, after the calendar year deductible.</td>
</tr>
<tr>
<td><strong>Physical Therapy</strong>&lt;br&gt;Limited to 60 visits per member each calendar year</td>
<td><strong>USA Health:</strong> Covered at 100% of the allowance, after the $10 office visit copay if charged.&lt;br&gt;<strong>Other PPO:</strong> Covered at 80% of the allowance, after the calendar year deductible.</td>
<td>Covered at 80% of the allowance, after the calendar year deductible.</td>
</tr>
<tr>
<td><strong>Dialysis - Renal Dialysis Facility</strong></td>
<td>Covered at 80% of the allowance, after the calendar year deductible.</td>
<td>Not covered.</td>
</tr>
</tbody>
</table>
Cardiac Rehabilitation
Limited to a maximum of 36 treatment sessions per cardiac episode

<table>
<thead>
<tr>
<th>USA Health</th>
<th>Other PPO</th>
<th>Not covered.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered at 100% of the allowance with no deductible.</td>
<td>Covered at 80% of the allowance, after the calendar year deductible.</td>
<td></td>
</tr>
</tbody>
</table>

Accident Related Dental Services if received within 90 days of the injury and treatment up to 180 days from injury

Covered at 80% of the allowance, after the calendar year deductible.
Treatment beyond 180 days requires pre-authorization of the treatment and coverage extends to only services received within 18 months of the date of injury.

Prescription Drugs
Physician-Administered Drugs
Precertification Required

The Prescription Drug benefit is administered by Express Scripts and explained at the start of this benefit summary. Precertification and assistance may be obtained by contacting Express Scripts at 1-800-698-3757 or Express-Scripts.com. You may also contact customer service at 1-855-687-3857 or www.express-scripts.com/activate or www.express-scripts.com/USAJAGS.

There may be a situation where your physician orders a specialty-drug through Blue Cross and Blue Shield. All physician-administered drugs must be precertified by BCBS. A list of physician-administered drugs that require precertification can be found at AlabamaBlue.com/web/pharmacy/drugguide.html. Precertification can be verified by calling BCBS customer service at 1-877-345-6171.

No benefits will be paid for physician-administered drugs if precertification is not obtained in advance.

Tobacco Cessation Assistance
Wellness Incentive
Quit for Life®

The Plan provides a tobacco cessation program that provides support to participants through telephone-based counseling and nicotine replacement therapy. Quit for Life® can be accessed at 1-888-768-7848. The Plan provides a Wellness Incentive in the form of a $50.00 credit on the monthly premium cost for the employee when the covered employee and spouse do not use tobacco products. The employee and spouse (if eligible under the Plan) who do not use tobacco products may file a Tobacco Declaration Form with the University’s Human Resources Department and qualify for the Wellness Incentive credit. The Plan provides for an annual recertification or when there is a change in tobacco status. The Plan provides an alternative method for obtaining the Wellness Incentive if you or your eligible spouse are unable to participate in the tobacco cessation program and you may contact the Human Resources Department for information on the alternative method. New employees must certify their tobacco status (and their spouse’s tobacco status if covered as a dependent) upon enrollment for the Plan. Additional information about this program may be obtained from the University’s Human Resources Department.

USA Health & PPO Providers

There will be situations where a specific medical treatment is required which is not available through USA Health. In such situations the Plan will not make an exception to the higher deductible or copayment requirement because there is not an available service provider in the USA Health network.

The deductible and copayment requirements of the Plan are established based on the most favorable economics. This is a shared savings arrangement unique to the USA Health. The higher deductible and copayment requirements would be charged on all medical providers if it were not for the special arrangement with the USA Health.

The keystone of the Plan is to incent utilization of USA Health Providers where the cost is lower. This arrangement acknowledges that not all medical services are offered through USA Health providers. Where those services are not offered the benefit will be less. In fact, if it were not for USA Health Providers, all benefits would be reduced. The use of a non-USA Health provider means that there is no available savings to be shared.
The Base Plan offers some preventive care services at 100%, with no deductible or copay, but only when received by a USA Health Provider. The following lists some of the immunizations and preventive services available. In some cases the preventive service may be billed separately from the office visit or facility visit and in that case and in all cases where the primary purpose is non-routine the office visit or outpatient facility copay will apply. The Base Plan does not comply with all ACA mandated preventive services due to Grandfathered status.

<table>
<thead>
<tr>
<th>BENEFIT</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Routine Newborn Care</strong></td>
<td>Covered at 100% of the allowed amount with no deductible or copay</td>
<td>Not covered.</td>
</tr>
<tr>
<td>Inpatient physician visits and Newborn Hearing Test</td>
<td>USA Health: Covered at 100% of the allowance, no copay.</td>
<td></td>
</tr>
<tr>
<td><strong>Well Child Care</strong></td>
<td>USA Health: Covered at 100% of the allowance, no copay.</td>
<td>Not covered.</td>
</tr>
<tr>
<td>Includes 9 visits during the first two years of the child’s life and one visit each year thereafter through age 6</td>
<td>Other PPO: Covered at 100% of the allowance after a $30 copay.</td>
<td></td>
</tr>
<tr>
<td><strong>Developmental Screening</strong></td>
<td>USA Health: Covered at 100% of the allowance, no copay.</td>
<td>Not covered.</td>
</tr>
<tr>
<td>Three exams between 9 months and 30 months of life</td>
<td>Other PPO: Covered at 100% of the allowance after a $30 copay.</td>
<td></td>
</tr>
<tr>
<td><strong>Routine Office Visit</strong></td>
<td>USA Health: Covered at 100% of the allowance, no copay.</td>
<td>Not covered.</td>
</tr>
<tr>
<td>Limited to two visits every two years for ages 7-34 and two visits each year for ages 35 and over.</td>
<td>Other PPO: Covered at 100% of the allowance after a $30 copay.</td>
<td></td>
</tr>
<tr>
<td><strong>Routine Immunizations</strong></td>
<td>USA Health: Covered at 100% of the allowance, no copay.</td>
<td>Not covered.</td>
</tr>
<tr>
<td><a href="http://www.bcbsal.com/immunizations">www.bcbsal.com/immunizations</a></td>
<td>Other PPO: Covered at 100% of the allowance after a $30 copay.</td>
<td></td>
</tr>
<tr>
<td><strong>Routine Pap Smear</strong></td>
<td>USA Health: Covered at 100% of the allowance, no copay.</td>
<td>Not covered.</td>
</tr>
<tr>
<td>Limited to one per calendar year</td>
<td>Other PPO: Covered at 100% of the allowance after a $30 copay.</td>
<td></td>
</tr>
<tr>
<td><strong>Human Papillomavirus (HPV) Screening</strong></td>
<td>USA Health: Covered at 100% of the allowance, no copay.</td>
<td>Not covered.</td>
</tr>
<tr>
<td>One screening every three years for females age 30 and older</td>
<td>Other PPO: Covered at 100% of the allowance after the $30 copay.</td>
<td></td>
</tr>
<tr>
<td><strong>Routine Chlamydia Screening</strong></td>
<td>USA Health: Covered at 100% of the allowance, no copay.</td>
<td>Not covered.</td>
</tr>
<tr>
<td>One per year for females ages 15-24</td>
<td>Other PPO: Covered at 100% of the allowance after the $30 copay.</td>
<td></td>
</tr>
<tr>
<td><strong>Routine Mammograms</strong></td>
<td>USA Health: Covered at 100% of the allowance, no copay.</td>
<td>Not covered.</td>
</tr>
<tr>
<td>One base-line for females ages 35-39; females age 40 and older, limit one per calendar year</td>
<td>Other PPO: Covered at 100% of the allowance after the $30 copay if charged.</td>
<td></td>
</tr>
<tr>
<td><strong>Prostate Screening</strong></td>
<td>USA Health: Covered at 100% of the allowance, no copay.</td>
<td>Not covered.</td>
</tr>
<tr>
<td>Males age 40 and over, limit one</td>
<td>Other PPO: Covered at 100% of the allowance after the $30 copay.</td>
<td></td>
</tr>
<tr>
<td>Prostate Specific Antigen and one Digital Rectal Exam each year</td>
<td>USA Health: Covered at 100% of the allowance, no copay.</td>
<td></td>
</tr>
<tr>
<td><strong>Routine Colorectal Cancer Screening – Age 50 and over</strong></td>
<td>USA Health: Covered at 100% of the allowance, no copay; includes associated office visit.</td>
<td>Not covered.</td>
</tr>
<tr>
<td>Hemocult stool check and Fecal occult blood test once each year – Sigmoidoscopy every 3 years – Double-contrast barium enema every 5 years – Colonoscopy every 10 years</td>
<td>Other PPO: Covered at 100% of the allowance including the associated office visit after the $30 copay.</td>
<td></td>
</tr>
<tr>
<td>(outpatient hospital services may require a copay)</td>
<td>USA Health: Covered at 100% of the allowance, no copay.</td>
<td></td>
</tr>
<tr>
<td><strong>Routine Endoscopy</strong></td>
<td>USA Health: Covered at 100% of the allowance, no copay.</td>
<td>Not covered.</td>
</tr>
<tr>
<td>Includes associated office visit</td>
<td>Other PPO: Covered at 100% of the allowance after the $30 copay.</td>
<td></td>
</tr>
<tr>
<td><strong>Other Routine Screenings</strong></td>
<td>USA Health: Covered at 100% of the allowance, no copay.</td>
<td>Not covered.</td>
</tr>
<tr>
<td>When necessary: Cbc, Tb Skin Test, Urinalysis. Cholesterol test once every 5 years.</td>
<td>Other PPO: Covered at 100% of the allowance after the $30 copay.</td>
<td></td>
</tr>
<tr>
<td><strong>Osteoporosis (Bone Density)</strong></td>
<td>USA Health: Covered at 100% of the allowance, no copay.</td>
<td>Not covered.</td>
</tr>
<tr>
<td>Limit 1 every 2 years, age 65 and older and younger if at risk</td>
<td>Other PPO: Covered at 100% of the allowance after the $30 copay.</td>
<td></td>
</tr>
<tr>
<td><strong>Vision Screening (One per year)</strong></td>
<td>USA Health: Covered at 100% of the allowance after the $30 copay.</td>
<td>Not covered.</td>
</tr>
</tbody>
</table>
 Covered mental health and substance abuse disorder treatment must be rendered or prescribed by a Psychiatrist, Psychologist, Licensed Professional Counselor or Licensed Clinical Social Worker.

### Inpatient Facility Services Limitations:
Covers up to 30 days of inpatient treatment per year, no coverage after 30 days (combined in-network and out-of-network); limited to maximum 60 days, lifetime. Out-of-Network coverage available only for medical emergencies or accidental injuries.

### Inpatient Physician Services Limitations:
Covered at 80% of the allowance after the calendar year deductible.

### Outpatient Mental Health Physician Services Limitations:
Outpatient Mental Health Physician Services; limited to treatment in a residential facility or free-standing substance abuse facility only.

### Outpatient Mental Health Physician Limitations:
Outpatient Mental Health Physician Services; limited to treatment in a residential facility or free-standing substance abuse facility only.

### Substance Abuse Disorder Outpatient Physician Limitations:
Limited to 60 visits per member each year combined with Substance Abuse Disorder Outpatient Physician Services; limited to treatment in a residential facility or free-standing substance abuse facility only.

### Residential Treatment Facility or Free-standing Substance Abuse Facility:
A licensed facility that maintains hours of service for at least 20 hours per week and may also include half-day programs that provide services for less than 4 hours per day with services managed by a physician.

### Tobacco Cessation Assistance
A program designed to assist with stopping the use of tobacco products. The program, which is paid for by the University of South Alabama and offered at no cost to the member, includes five counseling sessions, educational materials and unlimited support by phone. The program also includes a benefit for nicotine replacement such as patches, lozenges, gum and the drug, Chantix. This program has been approved by the American Cancer Society. The program is provided by Blue Cross Blue Shield of Alabama and you or your spouse may enroll by calling 1-888-768-7848. This program is not offered to dependent children.
USA Health & Dental Plan – Dental Plan – Benefit Summary

DENTAL BENEFIT

BASE PLAN – Grandfathered Status
DENTAL BENEFIT PREFERRED PROVIDER NETWORK

The USA Health & Dental Plan offers dental benefits using a Preferred Provider Network of dental providers who contract with Blue Cross Blue Shield of Alabama (BCBS). The Dental Network is a statewide network. This managed care program is designed to promote quality and cost effective dental care. Network dentists will file all claims and accept the BCBS allowed amount or allowance as payment in full (after any deductible and coinsurance you are required to pay). Payments for covered services provided by in-network dentists in Alabama are based on the dental network fee schedule (allowed amount or allowance) which establishes the maximum amount to be paid for services rendered by an Out-of-Network dentist.

Payments for covered services provided by Out-of-Network dentists in Alabama will be made according to the dental network fee schedule at the same level as In-Network services. However, you may be responsible for the difference between the BCBS allowance and the dentist’s charge (plus any deductible and coinsurance). You may also have to file the claim if your dentist’s office will not do so. Payments for covered services received outside Alabama will be paid at the lesser of the amount BCBS will recognize as the “allowed amount” or the amount charged by the dentist.

GENERAL PROVISIONS

<table>
<thead>
<tr>
<th>Deductible</th>
<th>$25 per member each calendar year limited to three (3) per family.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefit Maximum</td>
<td>$1,000 per member each calendar year (no family maximum). The $1,000 per member maximum does not apply to members under the age of 19 years.</td>
</tr>
</tbody>
</table>

DIAGNOSTIC AND PREVENTIVE (Exams and Cleanings)

Covered at 100%, with no deductible, includes:

- Dental exams up to twice per calendar year.
- Full mouth X-rays, one set during any 36 consecutive months.
- Bitewing X-rays, up to twice per calendar year.
- Other dental X-rays, used to diagnose a specific condition.
- Routine cleanings, twice per calendar year.
- Tooth sealants on teeth numbers 3, 14, 19, and 30, limited to one application per tooth each 48 months. Benefits are limited to a maximum payment of $20 per tooth. Limited to the first permanent molars of children through age 13.
- Fluoride treatment for children through age 18 twice per calendar year.
- Space maintainers (not made of precious metals) that replace prematurely lost teeth for children through age 18.

RESTORATIVE (Fillings and Root Canals)

Covered at 80%, after the deductible, includes:

- Fillings made of silver amalgam and synthetic tooth color materials (tooth color materials include composite fillings on the front upper and lower teeth numbers 5-12 and 21-28; payment allowance for composite fillings used on posterior teeth is reduced to the allowance given on amalgam fillings).
- Simple tooth extractions.
- Repairs to removable dentures.
- Emergency treatment for pain.
### SUPPLEMENTAL (Oral Surgery and Anesthesia)

Covered at 80%, after the deductible, includes:
- Oral surgery for tooth extractions and impacted teeth and to treat mouth abscesses of the intra-oral and extra-oral soft tissue.
- General anesthesia given for oral or dental surgery. This means drugs injected or inhaled for relaxation or to lessen pain, or to make unconscious, but not analgesics: drugs given by local infiltration, or nitrous oxide.
- Treatment of the root tip of the tooth including its removal.

### PROSTHETIC (Crowns and Dentures)

Covered at 50%, after the deductible, includes:
- Full or partial dentures.
- Fixed or removable bridges.
- Inlays, onlays, veneers, or crowns to restore diseased or accidentally broken teeth, if less expensive fillings are not adequate.

### PERIODONTIC (Gum Disease)

Covered at 50%, after the deductible, includes:
- Periodontic exams twice each 12 months.
- Removal of diseased gum tissue and reconstructing gums.
- Removal of diseased bone.
- Reconstruction of gums and mucous membranes by surgery.
- Removing plaque and calculus below the gum line for periodontal disease.

Payments are based on the “Allowed Amount.” Benefits are subject to the terms, limitations and conditions of the group contract.

### YOUR IDENTIFICATION CARDS

The **Blue Cross Blue Shield** and **Express Scripts** identification cards contain information that is important to you and vital to the correct filing of your claim for benefits under the Plan. ID cards are issued to Eligible Employees, with the name of the Eligible Employee printed on the card; each Member of your family may carry an ID card.

Your ID card also includes your Contract Number, Group Number, and Effective Date. You should show your Blue Cross Blue Shield ID card to each provider of medical and dental services. You should show your Express Scripts ID card to the physician and pharmacy. Your ID card will ensure that your claim is properly filed.

The ID card lists phone numbers to assist you with filing a claim. The most important is the Customer Service number. If you have a claim problem or need information about the Plan you should contact Customer Service.
**HEALTH PLAN COVERED SERVICES**

**COVERED SERVICES**

Covered Services include only the services, supplies and expenses listed in this Member Handbook as eligible for coverage or approved by the Claims Administrator. Covered Services do not include any service, supply or expense not specifically stated as a Covered Service eligible for benefits or approved by the Administrator; any service, supply or expense which is specifically excluded; any amount in excess of the Allowed Amount; and any charge or amount in excess of a specifically stated Plan maximum.

It is important that you read the Member Handbook so you will understand the benefits available to you and the restrictions that apply to some Covered Services. Some Covered Services are available only when rendered by a Blue Cross Blue Shield Provider and some Covered Services are limited or restricted. It is important that you understand the lowest Copay amounts are available only when the Covered Service is rendered by a USA Health Provider.

**INPATIENT HOSPITAL BENEFITS**

Precertification is required for all hospital admissions (general hospitals and psychiatric specialty hospitals) except for medical emergency services and maternity admissions. Medical emergency admissions require certification within 48 hours of admission:

**1-800-248-2342 (toll-free)**

Generally, if precertification is not obtained, no benefits will be payable for the hospital admission or the services of the admitting physician.

A newborn child remaining in the hospital after the mother is discharged will be treated as a new admission for the newborn. Precertification will be required only if the baby is transferred to another facility or the baby is discharged and then readmitted.

The Plan covers the following services and supplies provided to a Member while a patient in a Hospital:

1. Bed, board and general nursing care in a semi-private room. A private room charge in excess of the semi-private rate is the responsibility of the Member.
2. Use of special hospital units such as intensive care or burn care and the hospital nurses who staff them.
3. Use of operating, delivery, recovery, and treatment rooms and equipment.
4. Anesthesia including supplies, use of equipment and administration by a Hospital employee.
5. Casts, splints, surgical dressings, treatment and dressing trays.
6. Diagnostic tests, including X-rays, laboratory exams, metabolism tests, cardiographic exams, encephalographic exams.
7. Physical therapy, hydrotherapy, chemotherapy, and radiation therapy.
8. Oxygen and its administration.
9. All drugs and medicines administered in the hospital.
10. Regular nursery care and diaper service for a newborn.

Multiple hospital stays will have all days apply toward the maximum number of inpatient days if the discharge and readmission is within 90 days.

The Claims Administrator may determine the level of hospital benefits based on appropriate medical care required to treat the patient’s condition. Some services may be denied if not medically necessary as determined by the Claims Administrator.

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No benefits are payable for an inpatient hospital admission in an out-of-network hospital except to treat an accidental injury or medical emergency. Inpatient hospital benefits for treatment of mental health and substance abuse disorders are available in the Alabama service area only if the hospital is an in-network provider.
OUTPATIENT HOSPITAL BENEFITS

Precertification is required for outpatient hospital services such as: outpatient diagnostic lab, X-ray, pathology, and physician-administered specialty drugs – for certification call –

1-800-248-2342

Home health and hospice when services are rendered outside the state of Alabama – for certification call –

1-800-821-7231

A list of the outpatient hospital, physician and other covered services requiring precertification can be found at –

www.AlabamaBlue.com/precert

The following are Covered Services for outpatient treatment subject to all provisions, limitations and exclusions of the Plan:

1. Charges by the Hospital for treatment of an Accidental Injury or Medical Emergency.
2. Charges by the Hospital for surgery in the outpatient department.
3. Hospital charges for hemodialysis and peritoneal dialysis for end-stage renal disease when the facility is approved for participation in the Medicare program.
4. Services for removal of impacted unerupted teeth or other dental processes when full surgical and support services are determined Medically Necessary.
5. Hospital charges for pre-operative laboratory tests, X-rays, and other diagnostic related tests ordered by the attending Physician and conducted within seven days prior to surgery.
6. Charges by an ambulatory surgical facility.
7. IV therapy, chemotherapy and radiation therapy.
8. Outpatient hospital benefits include physician-administered specialty drugs.

PHYSICIAN BENEFITS

Benefits apply only to the physician’s charges for service indicated, including:

1. Medical care and treatment including office visits and second surgical opinions, hospital visits, and outpatient treatment of an Accidental Injury or Medical Emergency.
2. Surgical operations and procedures, including the active services of an assisting surgeon when Medically Necessary.
3. Anesthetics and their administration, including supplies and use of equipment, when rendered by a Physician (other than the operating surgeon or obstetrician).
4. Diagnostic lab, X-ray and pathology services in the Physician’s office (if laboratory results are generated in the outpatient department of a hospital or an independent lab and the charges billed separate, the benefit will be subject to any applicable outpatient facility copay).
5. Services of a radiologist or pathologist.
7. Inpatient consultation by a specialist Physician for a medical, surgical or maternity condition, limited to one for each Hospital stay.
8. Physician services for bariatric surgery, gastric bypass restrictive procedures and complications are limited and specific only to a physician who is participating in the Blue Cross Blue Shield Bariatric Surgery Network. The Plan provides benefits for only one surgical procedure for obesity during a member’s lifetime and only if the surgery is medically necessary and the member has complied with the Claims Administrator’s medical guidelines for treatment of morbid obesity. Limitations and guidelines can be found at –

www.AlabamaBlue.com

“Medical Policies” under “Research & Tools”

Outpatient Hospital, Physician and Other Services requiring precertification:

Precertification is required for certain outpatient hospital benefits, physician benefits, physician-administered drugs, and other covered services. Generally, services requiring precertification are listed herein. In addition, covered services that require precertification can be found at AlabamaBlue.com/precert.

Some Specialty Drugs must be precertified by the pharmacy administrator, Express Scripts, and you can contact customer service at 1-855-687-3857 or www.express-scripts.com/USAJAGS.
PREGNANCY AND DELIVERY

The following are Covered Services:

2. Obstetrical care, including Physician services, during Pregnancy and childbirth.
4. Inpatient Hospital expenses for delivery. If care is rendered for multiple births during the same Pregnancy, the Plan will pay the largest Allowed Amount regardless of the number of babies delivered or method(s) of delivery.

The following services are covered only when the newborn child is delivered by the Employee or Spouse:

1. Physician visits for routine newborn care and a Universal Newborn Hearing Test.
2. In most cases, a well baby’s charges will be listed under the charges for an inpatient hospitalization. In the case of a sick baby, when the baby incurs charges under its own name, charges will be covered under inpatient Hospital benefits, subject to any applicable inpatient Hospital Deductible and daily Copay.
3. Circumcision of a newborn baby.

The following are not Covered Services:

1. Newborn care of any kind for any illness when the child is delivered by an Eligible Dependent other than the Employee’s Spouse.
2. Fertility testing and treatment including ART, tubal transfer, in vitro fertilization, gamete intrafallopian transfer or zygote intrafallopian transfer and pro-nuclear stage tubal transfer.
3. Genetic testing.
4. Ultrasound or related tests performed primarily to determine the sex of the unborn child.
5. Ambulance service not certified by a Physician as Medically Necessary.

Newborns’ & Mothers’ Health Protection Act:

Federal law prohibits restricting benefits for a hospital length of stay for childbirth for the mother or newborn child to less than 48 hours following vaginal delivery or less than 96 hours following a Cesarean section.

MENTAL HEALTH AND SUBSTANCE ABUSE

Treatment for a mental condition which includes (whether organic or non-organic, of biological, non-biological, genetic, chemical or non-chemical origin, irrespective of cause, basis or inducement) a mental disorder, mental illness, psychiatric illness, nervous condition, neurotic, schizophrenic, affective or personality disorder, psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohumoral systems. Covered Services include inpatient and outpatient Mental Health and Substance Abuse Treatment. Services must be rendered or prescribed by a Psychiatrist, Psychologist, Licensed Clinical Social Worker (LCSW) or Licensed Professional Counselor (LPC).

Precertification is required for hospital admissions including general hospital and psychiatric specialty hospitals.

The Plan does not comply with the Mental Health Parity Act but opts-out of compliance based on its status as a self-funded governmental health plan. The Plan does not provide parity of benefits but limits services to annual and lifetime maximums. Services, supplies and treatment for mental health disorders and substance abuse disorders may be covered subject to benefit maximums, coinsurance and deductibles. You should always check your recommended medical treatment with Blue Cross Blue Shield to be sure of the benefits available.

ORGAN AND BONE MARROW TRANSPLANTS

Benefits are available for services and expenses in connection with some transplants of organs and tissues. These include only transplants of: (1) heart; (2) liver; (3) lungs; (4) pancreas/islet cell; (5) kidney and (6) intestinal/multivisceral. Bone marrow transplants, which include stem cells and marrow to restore or make stronger the bone marrow function, are also included. All organ and bone marrow transplants (excluding kidney) must be performed in a hospital or other facility on the BCBS list of approved facilities for that type of transplant and it must have the advance written approval of the Claims Administrator.

Covered transplant benefits for the recipient include any medically necessary hospital, medical-surgical and other services related to the transplant, including blood and blood plasma. Transplant benefits for cadaveric donor organ costs are limited to search, removal, storage, and transporting the organ and removal team.
Transplant benefits for living donor expenses are limited to: solid organs, bone marrow, prediagnostic testing, hospital and surgical expenses for removal of the donor organ, transportation, post-operative hospital, medical, laboratory and other services for the donor related to the organ transplant limited to up to 90 days of follow-up care after the date of donation.

Expenses are subject to the Allowed Amount and other Plan provisions and limitations. The Plan reserves the right to set the maximum expense it feels to be reasonable for the transplant procedure and necessary for the maintenance of good health of the Member.

The Member must contact Blue Cross Blue Shield of Alabama and specifically the Individual Case Management and Care Management Programs to work with a medical coordinator. All services must be precertified.

There are no transplant benefits for: experimental or investigative; artificial or mechanical devices; organ or bone marrow transplants from animals; donor costs available through other group coverage; if any government funding is provided; the recipient if not covered by this Plan; donor costs if the recipient is not covered by this Plan; recipient or donor lodging, food, or transportation costs, unless specifically stated in the Plan; a condition or disease for which a transplant is considered investigative; transplants (excluding kidney) performed in a facility not approved in writing in advance of the procedure by the Claims Administrator.

Tissue, cell and any other transplants not listed above are not included in this organ and bone marrow transplant benefit but may be covered under other provisions of the Plan when determined to be medically necessary and not investigative. These transplants include: heart valves, tendon, ligaments, meniscus, cornea, cartilage, skin, bone, veins, etc.

HOME HEALTH CARE

Benefits for Home Health Care are provided only when a Blue Cross Blue Shield Provider is used.

All services and expenses must be submitted to the Claims Administrator for Precertification. No Home Health Care service or expense is a Covered Service until approval is obtained. Home Health Care Covered Services include:

1. Nursing Care – intermittent services (less than an eight-hour shift) provided by a registered nurse, licensed practical nurse or home health aide. No benefits are provided for Custodial Care.

2. Durable Medical Equipment – equipment, such as wheelchairs, hospital beds, external insulin infusion pumps, and initial placement and replacement of prosthetic, orthotic and orthopedic devices, certified as Medically Necessary by the Claims Administrator to treat an Illness or Injury, or to improve the functions of a malformed body member. Rental of Durable Medical Equipment is covered provided the aggregate rental charges do not exceed a reasonable purchase price; purchase may be approved if purchase is less costly than rental.

3. Home Care Medical Supplies – medical supplies ordered by an In-Network Physician for home use and required due to chronic Illness, limited to only: oxygen, IV therapy solutions, crutches, splints, casts, trusses and braces, specialty dressings for open wounds, syringes and needles, blood glucose strips, lancets and glucose monitors, tubing kits for insulin pumps, catheters, colostomy bags, compression stockings and medical supplies required in conjunction with an authorized Home Health Care visit.

HOSPICE CARE

Hospice Care is provided only to Terminally Ill Members, and includes Physician home visits, home physical therapy and medical social services, or inpatient Hospice Care when there are no suitable caregivers available to provide care at home for a Terminally Ill Member, or to provide temporary relief for a caregiver. Hospice Care is limited to a lifetime maximum benefit of 180 days and must be furnished by an In-Network provider.
OTHER COVERED SERVICES

The following are also Covered Services subject to all Plan provisions, limitations and exclusions:

1. **Allergy testing** and treatment, including serum.
2. **Ambulance** service to the nearest Hospital able to provide necessary care, and transportation to a Hospital for specialty care when ordered by a Physician.
3. **Blood** and blood plasma; visualizing dyes and other injections into the circulatory system for diagnosis and treatment.
4. **Cardiac rehabilitation**, when ordered by a Physician following cardiac surgery or as a preventive measure for cardiac-related diagnoses when precertified by the Claims Administrator.
5. **Certified Registered Nurse Anesthetist (CRNA)**, only when billed by the Hospital or supervising Physician. The Plan will pay the Hospital or supervising Physician for services.
6. **Colorectal cancer screening**, as provided under the Plan’s preventive care benefits. If additional colorectal cancer screenings are performed in connection with the diagnosis or treatment of a medical condition, and if the Physician files the claim with this information, the screening will be a Covered Service paid as a diagnostic procedure. If additional colorectal screenings are performed because you are at high risk of developing colon cancer or you have a family history of colon cancer, and if the Physician files the claim with this information, the screening will be a Covered Service paid as a diagnostic procedure.
7. **Contact lenses, eyeglasses**, one pair or one pair of each, if Medically Necessary to replace the human lens functions as a result of intraocular surgery or ocular injury or defect.
8. **Contraceptives**, including oral and injectable contraceptives, diaphragms, IUDs and other FDA-approved contraceptives, and required Physician services associated with contraceptive management. Oral contraceptives are covered under the Prescription Drug Card benefit.
9. **Diabetic Education**, lifetime maximum benefit of 5 classes subject to medical necessity and provided by a certified diabetic instructor.
10. **Diagnostic tests**, including laboratory exams, metabolism tests, and pathology. How benefits are paid for tests depends on where the test is performed, and where the results are generated. Diagnostic tests performed in the office of a USA Health Provider are covered at 100%. Diagnostic tests performed in the office of a Physician other than a USA Health Provider are covered at 100% when the results are generated by the Physician’s office; when the results are generated by the outpatient department of a Hospital or an independent lab, there may be a Copay.
11. **Diagnostic imaging**, including X-rays, CT Scans, MRIs, MRAs, CTAs and Petscans. How benefits are paid for diagnostic X-rays depends on where the test is performed, and where the results are generated. A diagnostic image performed in a Physician’s office is covered at 100%. A diagnostic image performed in the outpatient department of a USA Health hospital or outpatient center is covered at 100%; otherwise, the diagnostic image is covered at 100% after a $50 Copay.
12. **Durable Medical Equipment** includes only equipment certified as Medically Necessary by the Claims Administrator.
13. **Elective Abortion**, only when ordered by a Physician to protect the mother’s physical life, or the Pregnancy resulted from a criminal act, or the mother has AIDS or is a drug addict.
14. **Elective sterilization**, including vasectomy when performed in a Physician’s office, or tubal ligation when performed on an outpatient basis or with delivery as an inpatient.
15. **Eye examinations** for routine purposes, limited to a per-Member maximum benefit of once each Calendar Year.
16. **Hemodialysis** and peritoneal dialysis treatment for end-stage renal disease.
17. **Immunizations**, A listing of immunizations can be found at www.bcbsal.com/immunizations or you may contact Blue Cross Blue Shield’s customer service. Immunizations required solely for foreign travel or college admission are not covered.
18. **Licensed Professional Counselor (LPC)** or Licensed Clinical Social Worker (LCSW) under the benefits provided for Mental Health and Substance Abuse Treatment.
19. **Mammograms**, as provided under preventive care services. If additional mammograms are performed in connection with the diagnosis or treatment of a medical condition, and if the Physician files the claim with this information, the mammogram will be a Covered Service paid as a diagnostic procedure. If additional mammograms are performed because you are at high risk of developing breast cancer or you have a family history of breast cancer, and if the Physician files the claim with this information, the mammogram will be a Covered Service paid as a diagnostic procedure.

20. **Morbid Obesity** surgery, only within the Claims Administrator’s approved Network of Physicians for bariatric surgery and gastric restrictive procedures, when in compliance with the Claims Administrator’s guidelines, and when there is a documented history of unsuccessful attempts to reduce weight by more conservative measures. Only one surgical procedure for morbid obesity will be a Covered Service during a Member’s lifetime, regardless of whether the first such surgery was covered by this Plan.

21. **Nursing Care** includes only intermittent services (less than an eight-hour shift) provided by a registered nurse, licensed practical nurse or home health aide who is not related to the Member or regularly resides in the Member’s household. The services must be ordered by a Physician and performed outside of a Hospital or any other acute care facility setting by a Blue Cross Blue Shield Provider. No benefits are provided for Custodial Care.

22. **Oral surgery and restorative dentistry** when necessary for the prompt, initial treatment of Injury to sound natural teeth, caused by a force outside the oral cavity and body. Coverage for initial treatment includes necessary services that are provided within 12 months of the date of the Injury, including the first dental prosthesis such as a crown or bridge if necessary. Only the Physician’s charges for this treatment are Covered Services under the Health Plan. Refer to the Dental Plan section of this Member Handbook for information on services covered under the Dental Plan.

23. **Orthodontic and Periodontic** services required after Orthognathic surgery.

24. **Orthotic devices** placed inside or attached to a shoe to support, realign or change gait function, or to treat a varus or valgus deformity, calcaneal apophyseis, plantar fasciitis or calcaneal periostitis, including only gait plates, heel stabilizers, Whitman plates, Roberts plates, biomedical functional orthotics and Schaefer orthotics, and molded shoes to treat deformed or severely maligned or neuropathic sensitive feet, such as in diabetics. Orthotic devices are covered under Durable Medical Equipment benefits, limited to a maximum benefit of two pair each 12 consecutive month period.

25. **Physical therapy** or **occupational therapy** by a licensed therapist, who is not related to the Member, limited to a Maximum Benefit of 60 sessions each per Calendar Year.

26. **Physician Assistant (PA)**, **Nurse Practitioner (NP)**, **Certified Surgical Technician (CST)** or assistant surgical nurse services.

27. **Physical examinations**, but only as provided under the Plan’s preventive care benefits.

28. **Prosthetic appliances**, such as artificial limbs and eyes, required as a result of Injury or Illness incurred while covered under the Plan, and replacements as determined to be Medically Necessary, covered as Durable Medical Equipment under the Home Health Care benefit.

29. **Radiologist** or **pathologist** services, when ordered by a Physician, including radiation therapy and chemotherapy.

30. **Reconstructive surgery following mastectomy** for breast cancer including reconstructive surgery of the breast on which the mastectomy was performed, and of the other breast to produce a symmetrical appearance; prosthesis and coverage of physical complications resulting from all stages of the mastectomy, including lymphedemas. Coverage of prosthesis includes initial placement of the prosthesis and replacements as determined to be Medically Necessary; and the brassiere required to hold the prosthesis, limited to a maximum benefit of four (4) each Calendar Year.

31. **Reconstructive Surgery** when determined to be Medically Necessary and not for Cosmetic purposes or related to complications of Cosmetic services or Cosmetic surgery.
20. after the Dental Plan.

21. to the Dental Plan section of this Member

22. Injury, including the first dental prosthesis such

23. are provided within 12 months of the date of the

24. initial treatment includes necessary services that

25. out Injury to sound natural teeth, caused by a

26. Oral surgery and restorative dentistry

27. provided for Custodial Care.

28. by a registered nurse, licensed practical nurse or

29. surgery was covered by this Plan.

30. lifetime, regardless of whether the first such

31. Only one surgical procedure for morbid obesity

32. reduce weight

33. for bariatric surgery and gastric restrictive

34. Morbid

35. the mammogram will be a Covered Service paid

36. have a family history of breast cancer, and if the

37. high risk of

38. mammograms are performed because you are at

39. as a diagnostic

40. Physician files the claim with this information,

41. necessary; and the brassiere required to hold the

42. replacements as determ

43. initial placement of the prosthesis and

44. lymphedemas. Coverage of prosthesis includes

45. for

46. therapy and chemotherapy.

47. Equipment under the Home Health Care benefit.

48. Necessary, covered as Durable Medical

49. replacements as determined to be Medically

50. incurred while covered

51. covered under Durable Medica

52. such as in diabetics.

53. severely maligned or neuropathic sensiti

54. orthotics, and molded shoes to treat deformed or

55. sta

56. only

57. physical complications resulting

58. produce a symmetrical appearance; prosthesis

59. surgery of the breast on which the mastectomy

60. for

61.Physician

62. sessions each per Calend

63. Member, limited to a Maximum Benefit of 60

64. licensed therapist, who is not related to the

65. Physical therapy

66. maximum benefit of 60 treatment sessions.

33. Speech therapy and audiology services,

34. required due to an Illness or Injury or to correct

35. speech deficiencies including but not limited to
devolutional articulation disorders and

36. stuttering. Speech therapy includes treatment of

37. speech, language, voice, communication and

38. auditory processing disorders, including medical
diagnostic evaluation, when provided by a

39. licensed therapist who is not related to the

40. Member; limited to a Calendar Year maximum

41. BE AS HEALTHY AS YOU CAN BE

42. Blue Cross Blue Shield wants you to be as healthy as you can be. That’s why BCBS created the Be Healthy

43. website to provide you with personalized information and tools to help you take control of your health.

44. At behealthy.com, customizing the site to fit your needs is easy. Just complete the health assessment tool,

45. HealthQuotient™. The site will then be tailored to fit your personal health needs and provide you with

46. informative health tools based on your assessment. If you’re concerned about the privacy or your

47. information, there’s no need to worry. Behealthy.com is a secure website, and your information will be

48. kept private and confidential.

49. Taking advantage of all the Be Healthy website has to offer is easy. Just go to www.behealthy.com and

50. sign in using your CustomerAccess ID and password. If you are not currently a CustomerAccess user, you

51. will need to register for this service (click “Register Now for CustomerAccess”).

52. Use the Be Healthy website as your personal resource for health and wellness information. You’ll have

53. access to health tools and trackers, the latest news and information about health topics, and more – all

54. customized for you. And since this website is powered by WebMD, a respected source of online medical

55. information, you can rest assured that this is a resource you can depend on for the most up-to-date,

56. comprehensive health information.
PLEASE READ THIS SECTION CAREFULLY.
The following conditions, services and expenses are not covered under any part of the Plan. Because it is impossible to create an all-inclusive list, the Plan reserves the right to review and exclude any services or expenses for conditions or procedures as necessary to avoid adverse selection and to protect the integrity of the Plan.

EXCLUSIONS BY PROVISION

Services and expenses, even if Covered Services, are excluded from coverage under the Plan due to the following terms, conditions and Plan provisions:

1. The service or expense is not specifically listed as a Covered Service, or is a complication arising from a condition or service that is not covered by the Plan.

2. The service, expense or treatment was not determined by the Claims Administrator to be Medically Necessary, including when services are provided for the personal comfort or convenience of the Member, or the Member’s caregivers.

3. The service or expense is received Out-of-Network and is a Covered Service only when received from or authorized by a Blue Cross Blue Shield In-Network Provider.

4. The service or expense is received without Precertification and is a Covered Service only when Pre-Certified.

5. A claim for services and expenses has not been received by the Claims Administrator within 12 months of the date of service.

6. The claim for services or expenses was not properly submitted according to the instructions provided in the section titled How to File a Claim for Benefits in this Member Handbook.

7. The service, expense or treatment was not required, referred, prescribed or arranged by a Physician.

8. Charges for Covered Services in excess of the Allowed Amount or Allowance.


10. Covered Services received before the Member’s Effective Date of coverage.

11. Covered Services received after the Member’s date of termination of coverage.

12. Covered Services provided after your failure to provide verification of dependent status within 30 days of a request from the Human Resources Department or the Claims Administrator, and the individual’s coverage under this Plan has been terminated, retroactive to the earliest date the Claims Administrator was able to determine the individual ceased to be an Eligible Dependent.

13. Covered Services eligible for reimbursement in whole or part by Workers’ Compensation or employers’ liability laws, whether or not you file for such benefits or if liability is enforced against or assumed by an employer.

14. Injury or Illness resulting from war, declared or undeclared or Uniformed Services duty.

15. Injury or Illness incurred in connection with the commission of a crime or participation in a riot or civil commotion, or while the Member was confined in a penal institution.

16. Treatment received in a federal hospital or treatment facility owned or operated by the United States government or one of its agencies, except as provided by federal law.

17. Services or expenses of any kind to which a Member is, or upon application would be, entitled to coverage under Medicare, whether or not application has been made, except as provided by federal law.

18. Services for which the Member is under no legal obligation to pay, or a service for which no charge would have been made if the Member had not had health benefits coverage.
HEALTH BENEFIT EXCLUSIONS

The following conditions, situations, expenses and services are not Covered Services under the Health Plan, whether or not recommended by a Physician and certified as Medically Necessary:

**PRESCRIPTION DRUGS**

1. Cosmetic or weight loss specific prescriptions, nutritional or dietary supplements, including charges for megavitamin therapy.

2. Drugs that can be purchased without a written prescription (over the counter) and kits for home testing, including but not limited to HIV, pregnancy or allergies, except for diabetic supplies, which may be purchased over the counter and are covered under the Plan.

3. Drugs not used for the specific treatment of Illness or Injury, prescriptions related to an otherwise non-Covered procedure, uses of drugs for purposes not specifically approved by the FDA (off-label), or drugs not approved by the Claims Administrator.

4. Drugs prescribed for the purpose of terminating pregnancy.


6. Prescriptions purchased at a non-participating pharmacy.

7. Sexual dysfunction or inadequacy not related to organic disease, including progesterone or testosterone or their derivatives, Viagra™ or any other drugs prescribed to treat a sexual dysfunction or inadequacy that is not directly related to organic disease.

8. Smoking cessation treatments, including drugs and nicotine replacements except when provided through the USA Health & Dental Plan’s tobacco cessation program, Quit for Life® administered by Blue Cross Blue Shield for employees and spouses.

**MEDICAL & DENTAL EXPENSES**

9. Abortion, an elective abortion except to protect the physical life of the mother, or the Pregnancy was a result of a criminal act or the mother has AIDS or is a drug addict.

10. Acupuncture or acupressure treatment.

11. Anesthesia services or supplies or both by local infiltration.

12. Appliances, services or expenses for comfort or convenience including but not limited to air-purification units, air conditioners, allergy-free bedding, humidifiers, heating pads, whirlpool baths, environmental control units, hot tubs, exercise equipment, orthopedic mattresses, vacuum cleaners, swimming pools, electro-magnetic bone stimulators, elevators or stair lifts, wheelchair lifts for automobiles, motorized transportation devices, non-hospital adjustable beds, safety rails, blood pressure or monitoring equipment and any equipment that does not meet the definition of Durable Medical Equipment or Home Care Medical Supplies.

13. Assisted Reproductive Technology, including but not limited to tubal transfer, in vitro fertilization, gamete intrafallopian transfer or zygote intrafallopian transfer and pro-nuclear stage tubal transfer.

14. Bariatric surgery and gastric restrictive surgery and complications and expenses arising from that surgery when the surgery is provided by a Non-Participating Bariatric Surgery Network provider in Alabama or a Non-PPO provider outside Alabama.

15. Bed and board for an empty hospital bed when the patient is confined to a special care unit.

16. Claims not properly submitted within 12 months from the date of service.

17. Cochlear implants and related services.

18. Cosmetic treatments including surgery or drugs for Cosmetic purposes, and any complications or subsequent surgery related in any way to Cosmetic services or surgery. Reconstructive surgery is a covered benefit; cosmetic surgery is not. Reconstructive surgery provided by the Women’s Health and Cancer Rights Act is a covered benefit.

19. Court ordered tests, treatment or therapy ordered as a condition of parole, probation, custody, or visitation evaluation.

20. Custodial Care, sanitarium care, convalescent care or rest cures, except as provided under the Skilled Nursing Facility Benefit Limitation.

21. CyberKnife treatment rendered at a facility or by a provider other than the University of South Alabama Mitchell Cancer Institute.
22. **Dental** treatment or any services related to conditions of the teeth or supporting structures, including periodontal disease or gum disease, or caused through the activities of daily living such as biting, chewing, clenching and grinding. Physician’s charges for oral surgery and restorative dentistry are a Covered Service under the Health Plan when necessary for the prompt, initial treatment of Injury to sound natural teeth, caused by a force outside the oral cavity. Outpatient Hospital services for the removal of impacted unerupted wisdom teeth are covered under the Health Plan only when Medically Necessary due to the medical condition of the patient.

23. **Dental** implants, across, or just above the bone and related appliances and all related medical services and expenses.

24. **Emergency room services** or use of an emergency room physician for medical care which is not required as a result of a Medical Emergency.

25. **Experimental or Investigative** procedures, drugs, treatments, equipment or supplies. Refer to the Definitions section for additional information.

26. **Exercise or physical fitness** programs, weight reduction, weight control or dietary control procedures, or drugs for weight loss purposes, nutritional or dietary supplements, except for surgery to correct morbid obesity, when determined by the Claims Administrator to be Medically Necessary, based on criteria established by the Claims Administrator, to protect the life of the Member.

27. **Eyeglasses or contact lenses**, except for initial placement of contact lenses or eyeglasses if Medically Necessary to replace the human lens function as a result of intraocular surgery or ocular injury or defect.

28. **Federal hospital** or facility covered under the laws of the United States, any state, county, city, town or other governmental agency except as required by federal law.

29. **Foot care and treatments** including non-surgical treatment of feet, orthotic devices designed to simply support the arch or pad of the foot and that are not functioning to change a pathological gait or stance problem, orthopedic shoes or prescription shoes (except molded shoes), and routine foot care such as removal of corns or calluses or the trimming of nails, except trimming of mycotic nails.

30. **Genetic testing** or counseling, or other analysis to identify a variant genetic code, to detect a genetic disease or to predict the likelihood of developing a genetic disease.

31. **Hearing aids** or the implantation of prosthetic devices to improve hearing.

32. **Experimental or Investigative** treatment, procedures, facilities, drugs, drug usage, equipment, or supplies except for participation in an approved clinical trial.

33. **Immunizations**, except as provided under the preventive care benefits of the Plan.

34. **Infertility** studies, tests to determine fertility or the use of fertility drugs.

35. **Learning disability** therapy, testing or treatment including that for perceptual disorders or behavioral disorders.

36. **Mental Health & Substance Abuse Treatment** except as specified in the section titled Mental Health and Substance Abuse Treatment.

37. **Nursery care** of any kind for any illness when the child is delivered by an Eligible Dependent other than the Employee’s Spouse.

38. **Occupational therapy**, recreational therapy or educational therapy. Occupational therapy is covered only when Medically Necessary due to Illness or Injury as part of a regimen of physical therapy.

39. **Organ or tissue transplants** or related services not specifically listed in the section titled Organ and Bone Marrow Transplant – Benefit Limitation.

40. **Physical examinations** required for insurance policies, employment or educational institution screening, recreational activities or government licensing, except when such purposes are incidental to the routine preventive care benefits provided.

41. **Pre-operative lab tests** not conducted within seven days prior to surgery.

42. **Pregnancy** services including complications for any individual who is not an Eligible Dependent.

43. **Private duty nursing** care, except as provided for in the section titled Home Health Care – Benefit Limitation.

44. **Private room** charges while hospitalized, except when required by a Physician due to Medical Necessity.
45. **Psychological testing** or counseling, educational or vocational testing or training, testing for or treatment of learning disabilities or behavioral problems.

46. **Recreational** or educational therapy.

47. **Rehabilitative** hospital or facility confinement primarily for physical, speech or occupational therapy.

48. **Replacement or upgrade** of existing properly functioning durable medical equipment even if the warranty has expired.

49. **Reversal of elective sterilization.**

50. **Self-care or self-help** therapy or training, including but not limited to hypnosis, stress management, bio-feedback or behavior modification therapy.

51. **Surgical sex transformations** or treatment for complications resulting from surgical sex transformations unless approved in advance in writing by the Claims Administrator.

52. **Teleconsultations.**

53. **Transcutaneous Electrical Nerve Stimulation** (TENS) units and associated supplies, to treat chronic pain or other medical conditions.

54. **Travel and lodging** for any physical condition, whether or not required by a Physician.

55. **Ultrasound** when performed primarily to determine the sex of an unborn child.

56. **Vision therapy**, visual training, or orthoptics, or any eye surgery, including but not limited to refractive keratoplasty in all forms when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmatism (blurring).

57. **Weight reduction**, weight or dietary control treatment, or drugs for weight loss purposes, nutritional or dietary supplements. The only exception is surgery to correct morbid obesity, within the Claims Administrator’s approved Network of Physicians for bariatric surgery and gastric restrictive procedures, when determined to be Medically Necessary and performed according to the guidelines of the Claims Administrator and limitations of the Plan.

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**LIFESTYLE SOLUTIONS CAN HELP YOU MAINTAIN A HEALTHY LIFESTYLE**

Maintaining a healthy lifestyle can be a challenge. Sometimes we just need a little help, especially when it comes to making a change that could improve our health. With Blue Cross Blue Shield of Alabama’s LifeStyle Solutions programs, help is only a click away.

LifeStyle Solutions is a series of interactive online programs that help you maintain a healthy lifestyle and guide you to make positive changes to your health behaviors.

LifeStyle Solutions includes the following:

- Easy Start
- Healthier Diet
- Weight Loss
- Get In Shape
- Healthy Heart
- Your Healthy Living
- Stress Relief
- Smoke-Free
- Healthy Aging
- Diabetes-Fighting
- Cancer-Fighting
- Healthy Seniors
- Custom Program

Each program gives you access to:

- Engaging interactive tools and trackers to help you set and complete goals;
- Tools and resources to help you learn more about your health;
- Delicious, easy-to-make recipes;
- A personalized to-do-list with simple action items to promote health changes;
- Meal plans customized specifically for you; and
- A tailored, seven-day exercise plan.

To increase your chance of success, it’s important to focus only on one program at a time. After you finish a program, you can begin a new program to continue improving your health. If you’re ready to make a change, sign in at [www.behealthy.com](http://www.behealthy.com) and take the HealthQuotient™ (to find out which program will benefit you the most) or select “LifeStyle Solutions Programs” under Health Programs to get started.
DENTAL PLAN

The Dental Plan is designed to assist you and your covered dependents with the cost of dental care. The Dental Plan – Benefit Summary provides a listing of the benefit schedule.

The Preferred Dentist Dental Plan administered by Blue Cross Blue Shield of Alabama allows the Plan to use its purchasing power to negotiate with dental care providers. Negotiated savings are passed on to you through increased benefits when you use a Preferred Dentist.

The level of benefits you receive under the Dental Plan will vary depending on whether services are received from a Preferred Dentist or a Non-Preferred Dentist.

If you live outside of the Preferred Dentist Network Area, you will still receive benefits for dental services, but you may wish to make arrangements to receive benefits from a Preferred Dentist in order to maximize your benefits.

PREFERRED DENTIST BENEFITS

Services rendered and received from a dentist who participates in the Preferred Dentist program are eligible for Preferred Dentist Benefits. There are several advantages to using a Preferred Dentist:

1. The Preferred Dentist will arrange for Precertification of all dental services, if required, and will file your claim for you.

2. The Preferred Dentist has agreed to accept a negotiated fee for dental services as payment in full, except for any applicable Calendar Year Deductible and Copay.

3. The Preferred Dentist will not require that you pay for dental services up front. You may be required to pay up front any applicable Calendar Year Deductible or Copay, but the Preferred Dentist will file for the remaining balance directly with Blue Cross Blue Shield of Alabama.

Go to www.bcbsal.com for a list of In-Network dentists in your area.

NON-PREFERRED DENTIST BENEFITS

Benefits are reduced if you receive services from a Non-Preferred Dentist who does not participate in the Preferred Dentist program. If you choose to use a Non-Preferred Dentist, you must be aware of the following:

1. It will be your responsibility to arrange for Precertification of dental services, if required.

2. You must pay for your dental services up front, directly to the Non-Preferred Dentist, and then file for reimbursement, less any applicable Calendar Year Deductible and Copay, from Blue Cross Blue Shield of Alabama. A Non-Preferred Dentist may offer to file your claim for you, but it is your responsibility to see that the claim is filed correctly and in a timely manner.

3. Blue Cross Blue Shield of Alabama will pay only the Preferred Dentist negotiated fee. You will be responsible for paying the difference between the Preferred Dentist negotiated fee and the actual charges of the Non-Preferred Dentist, plus any applicable Calendar Year Deductible and Copay.

PREFERRED DENTIST DIRECTORY

A provider directory listing the network of Preferred Dentists is available online at the website www.bcbsal.com. From time to time providers are added and deleted from the network. It is your responsibility to check with your dentist prior to treatment to determine that the provider is still a Preferred Dentist.

FREEDOM OF CHOICE

You are not required to use a Preferred Dentist under the Dental Plan. You may choose to use a dentist who does not participate in the Preferred Dentist program, or you may live outside the Preferred Dentist Network area and find it inconvenient to use a Preferred Dentist. The increased benefits are not available for Non-Preferred Dentists.
DENTAL BENEFIT LIMITATIONS AND EXCLUSIONS

When there are two or more methods of treating a condition, payment for a Covered Service will be based upon the charges for the least expensive course of treatment.

The following situations, conditions, services and expenses are not covered under any part of your Dental Plan:

1. Anything excluded under the section of this booklet titled Exclusions by Provision.
2. Any service or expense covered under the Health Plan schedule of benefits.
3. Any service or expense that is not performed by a dentist, oral surgeon or a dental hygienist.
4. Any service or expense for which supporting proof of loss has not been properly submitted. Proof of loss may include clinical reports, charts, and X-rays.
5. Any service or expense related to the treatment of Temporomandibular Joint (TMJ) disorders; refer to the section titled Health Plan Covered Services for additional information.
6. Anesthetic services performed by a dentist other than the attending dentist or the attending dentist’s assistant.
7. Gold fillings, gold foil restorations or space maintainers made of precious metals. The Plan covers fillings of silver amalgam only, and composite (tooth-colored) fillings in the smile line.
8. Treatment of the teeth or gums for cosmetic purposes.
9. Prosthetics, including bridges and crowns, started or under way prior to the Member’s Effective Date under the Plan.
10. Re-basing or re-lining of a denture less than six months after the first placement, and not more than one re-basing or re-lining in any two-year period.
11. Replacement of lost or stolen prosthetics or replacement of prosthetics less than five years after a placement.
12. A new denture or bridgework if the existing device can be made serviceable.
13. Procedures, restorations and appliances to change vertical dimension or to restore proper contact between opposing teeth.
14. Any expense paid in whole or in part by any other provision of the Health Plan.
15. Any expense in excess of the Allowed Amount.
16. Orthodontia performed exclusively on primary teeth.
17. Any expense for oral hygiene or dietary information.
18. Any expense for plaque or infection control.
19. Any expense for implants or implantology.
20. Any expense for orthodontics or orthodontia.
GENERAL PLAN PROVISIONS

MEDICAL NECESSITY & PRECERTIFICATION

Benefits are provided for Covered Services listed herein and determined to be Medically Necessary by the Claims Administrator. You, your physician or medical provider decide on the medical treatment that best manages your medical condition and this may include care that is not covered by the Plan.

In some cases, such as in-patient hospital admission, the Plan requires Precertification by the Claims Administrator. You are responsible for making sure that your provider initiates and complies with any Precertification requirements under the Plan, call – 1-800-248-2342.

Medical Necessity determinations are made solely for the purpose of determining whether to pay for a medical service or supply. All decisions concerning treatment must be made solely by the attending physician, medical provider and the patient.

ALLOWED AMOUNT OR ALLOWANCE

The “Allowed Amount” or “Allowance” for all Covered Services is determined by the Claims Administrator. The Claims Administrator relies upon in-network provider negotiated rates to determine the relative value for services. The Allowed Amount may not correspond to the usual or customary charge made by a physician, hospital, dentist or other medical provider or by other physicians and medical providers in any geographic area. In no case will the Allowed Amount or Allowance exceed the limits established in this Plan.

Benefits for Covered Services are paid at the Allowed Amount or Allowance based on the fee schedule the Claims Administrator has contracted with its network providers. The provider has agreed to accept a negotiated fee for Covered Services. Members receiving benefits for Covered Services from Blue Cross Blue Shield Providers are not responsible for amounts billed in excess of this fee, except for any applicable Deductible or Copay. The Member is responsible for the amount billed in excess of the Allowed Amount or Allowance, plus any applicable Deductible or Copay, for services obtained from a non-participating provider.

If surgical care rendered consists of two or more related procedures performed during the same operative session, the Plan will pay only for the procedure with the largest Allowed Amount.

If the surgical care consists of two or more separate and unrelated procedures performed during the same session, the Plan will pay only for the procedure with the largest Allowed Amount, and one-half of the Allowed Amount for the other procedures.

When two surgeons in different specialties operate in the same operative field as co-surgeons with each assisting the other, the Plan’s payment will be made at 150% of the Allowed Amount for the surgical procedure, in which case the services of an assisting surgeon would not be Covered Services, as the co-surgeons assist each other.

If care is rendered for multiple births during the same Pregnancy, the Plan will pay the largest Allowed Amount regardless of the number of babies delivered or method(s) of delivery.

LIMITATION OF LIABILITY

The USA Health & Dental Plan benefits are paid as a general obligation. The University of South Alabama does not waive any sovereign immunity provided by state and federal constitutions or other laws. Notwithstanding any provision described in this document, the Plan will not create a debt for the State of Alabama.

The University has the power and authority to make additional rules and regulations concerning eligibility and benefits, and reserves the right to interpret the Plan and make final determinations with regard to all matters.

The University reserves the right to change, modify and terminate any and all benefits at its sole discretion. The University reserves the right to change, modify and terminate any and all benefits for any class of employees and dependents at its sole discretion. Eligibility and benefits are not guaranteed and continue on a month to month basis subject to change by the University. In the event of Plan termination, all Employee and dependent rights to benefits under the Plan will end effective with the date of termination.

The USA Health & Dental Plan Management Committee is charged with the responsibility and authority for management of the USA Health & Dental Plan as authorized in the Plan document. The agent for service of legal process is Blue Cross Blue Shield of Alabama, the Claims Administrator.
The University has, in this Member Handbook, tried to summarize as accurately as possible all pertinent provisions of the Plan as of the date this Member Handbook was prepared. However, in the event of any conflict between this USA Health & Dental Plan Member Handbook, regulations and administrative procedures, the University reserves the right to make final and conclusive determination.

The relationships between the University of South Alabama, the USA Health & Dental Plan, medical services providers and the Claims Administrator are independent contractor relationships.

Neither the University of South Alabama nor the USA Health & Dental Plan is liable for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by the Member while receiving care from any provider.

RIGHT TO RECEIVE AND RELEASE INFORMATION

To ensure that benefits are paid correctly, the Claims Administrator must receive information from providers of medical services and from insurance companies with whom benefits are coordinated. To determine if a claim should be paid or denied, or whether other parties are legally responsible for some or all of the expense, the Claims Administrator may exchange information with medical providers or other health Claims Administrators.

By enrolling in this Plan, you authorize the Claims Administrator to obtain, use and release all records about you and your Eligible Dependents that are needed in the administration of the Plan. You accept the obligation to provide the Claims Administrator with information on other group health insurance, other parties who may be legally responsible for medical expenses, Change-In-Status Events, and other reasonable information requested or required.

If you or any medical provider refuses to provide information requested, this Plan may deny benefits.

The Claims Administrator and the University of South Alabama strive to keep all information confidential. The Plan and the Claims Administrator will not be held liable for the use or misuse of information provided to other parties as required for the proper administration of the plan as regulated by the Privacy Policy.

COORDINATION OF BENEFITS (COB)

When a Member is covered by another group health plan, this Plan will coordinate its benefits with those of the other plan to prevent the total benefits paid exceeding 100% of the covered expenses incurred.

Coordination of benefits requires that the Claims Administrator determine which plan pays first (the primary plan) and which plan pays second (the secondary plan). If this Plan is primary, it will pay the full benefits due. If this Plan is secondary, the benefits it would have paid will be reduced to account for the benefits provided by the other plan.

The Coordination of Benefits (COB) rules apply to all group health plans. You can obtain the rules by contacting the Claims Administrator. This is a brief description of some of the important provisions.

Which plan is primary is decided by the first rule that applies:

Noncompliant Plan: If the other group health plan has no coordination of benefits provision, it is primary. If both plans include this provision, the following conditions apply in determining which plan is primary:

Employee/Dependent Rule: The plan covering the Member as an employee is primary over the plan covering the Member as a dependent.

Active/Inactive Employee Rule: The plan covering the Member as an active employee is primary over the plan covering the Member as an inactive employee (laid off or retired).

Dependent Child of Parents Not Separated or Divorced: If both plans cover the Member as a dependent child, the plan of the parent whose birthday falls earlier in the year will be primary. If the parents have the same birthday, the plan that has covered the parent longer is the primary plan.

Dependent Child of Separated or Divorced Parents: If there is a court order that specifically states that one parent must provide the dependent child’s health expenses, that parent’s plan is primary. In the absence of a court order, when two or more plans cover the Member as a dependent child, benefits are determined in this order:

1. first, the plan of the custodial parent;
2. second, the plan covering the custodial parent’s spouse;
3. third, the plan covering the non-custodial parent;
4. last, the plan covering the non-custodial parent’s spouse.
**Longer/Shorter Length of Coverage Rule:** If none of the above rules determines the order of payment, the plan covering the Member the longer time is primary.

**Determination of Amount of Payment:**

1. When this plan is primary, it shall pay benefits as if the secondary plan did not exist. When this plan is secondary no benefits will be paid prior to the primary plan’s benefit determination.

2. When this Plan is secondary, benefits will be provided up to the Allowed Amount that exceeds the payments of the primary plan, but in no case shall the benefits exceed the lesser of: (1) what this Plan would have paid in the absence of other coverage; or, (2) the expenses the Member was obligated to pay, which are covered in full or part by one of the plans involved.

A group health plan includes a PPO, HMO and all other forms of group-type coverage (insured or self-funded), medical care components of long-term care contracts, such as skilled nursing care, medical benefits under group or individual automobile contracts, and Medicare or any other federal governmental plan, as permitted by law. Group-type coverage means a contract that is not available to the general public and is maintained only because of membership in or a connection with a particular organization or group, including blanket coverage.

A statement of the Coordination of Benefits rules and regulations may be obtained by contacting Blue Cross Blue Shield of Alabama or the Human Resources Department. Each Member is obligated to assist with obtaining and providing information needed for coordination of benefits. Failure to assist the Claims Administrator with obtaining required information for coordination of benefits will result in a delay in the payment of benefits which might otherwise be paid.

**MEDICARE COORDINATION OF BENEFITS**

The Eligible Employee or Eligible Dependent eligible for Medicare will continue to be covered for the same benefits available to all Eligible Employees. This Plan will be primary and will pay its benefits first. Medicare will then pay for Medicare eligible expenses, if any, not paid by the Plan.

If an Eligible Employee or Eligible Dependent becomes eligible for Medicare benefits based solely on End Stage Renal Disease (ESRD), this Plan will be primary for the first 30 months of eligibility for Medicare. After the first 30 months of eligibility for Medicare, if the Eligible Employee or Eligible Dependent is still eligible for Medicare due to ESRD or for any other reason, Medicare will be primary.

The Employee or Dependent may elect Medicare as primary coverage, in which case this Plan will not pay any benefits. An Employee electing Medicare as primary coverage may have a Medicare supplement contract but the University is not allowed under the law to pay for such a contract.

Refer to the “Creditable Drug Coverage Notice” for additional information.

**UTILIZATION REVIEW**

Utilization review refers to the process conducted by the Claims Administrator to ensure the appropriate management and utilization of medical resources. Review may be performed prior to, concurrent with or retrospective of service in order to determine the most appropriate treatment setting for the patient’s severity of Illness. Review will also occur to determine Medical Necessity and clinical outcome. Payment of services may be denied if the services fall outside the utilization review guidelines or are not part of the schedule of benefits.

After the initial Precertification of a hospital admission, the Claims Administrator may contact the attending physician to determine if continued inpatient days are Medically Necessary. Any days not certified as Medically Necessary will not be covered by the Plan.
SUBROGATION – THE RIGHT TO RECOVER FROM A RESPONSIBLE THIRD PARTY

When the Plan pays benefits on behalf of any Member, the Plan is subrogated to all rights of recovery which that Member has in contract, tort, legal liability, settlement or otherwise against any person, entity or organization for the amount of benefits the Plan has paid or provided. That means the Plan may use your right to recover money from that other person or organization.

RIGHT OF REIMBURSEMENT

Besides the right of subrogation, this Plan has a separate right to be reimbursed or repaid from any money you recover, including your family members recover for an injury, illness or condition for which the Plan paid benefits. This means that you promise to repay the amount the Plan has paid or provided in benefits from any money you recover. It also means that if you recover money as a result of a claim or a lawsuit, whether by settlement or otherwise, you must repay the Plan. And, if you are paid by any person or company besides the Plan, including the person who injured you, that person's insurer, or your own insurer, you must repay the Plan.

This Plan has the right to be reimbursed or repaid first from any money you recover, even if you are not paid for your entire claim for damages and you aren't made whole for your loss. This means that you promise to repay the Plan first even if the money you recover is for (or said to be for) a loss other than Plan benefits, such as pain and suffering. It also means that you promise to repay the Plan first even if another person or company has paid for part of your loss. And it means that you promise to repay the Plan first even if the person who recovers the money is a minor or dependent covered under the Plan. In these and all other cases, the Plan has the right to first reimbursement or repayment out of any recovery you receive from any source.

RIGHT TO RECOVERY

You agree to promptly furnish the Claims Administrator all information you have concerning your rights of recovery or recoveries from other persons or organizations and to fully assist and cooperate with the Claims Administrator in protecting and obtaining the Plan’s reimbursement and subrogation rights.

You or your attorney will notify the Claims Administrator before filing any suit or settling any claim to enable the Plan to participate in the suit or settlement to enforce the Plan’s rights. If you notify the Claims Administrator so the Plan is able to and does recover the amount of Plan benefit payments for you, the Plan will share proportionately with you the cost of any attorneys' fees charged to you by your attorney for obtaining the recovery.

If you do not give the Claims Administrator that notice, reimbursement or subrogation recovery under this section will not be decreased by any fee for your attorney. You further agree not to allow the Plan’s reimbursement and subrogation rights to be limited or harmed by any other act or failure to act on your part and, if you do, the Plan may suspend or terminate payment of any further benefits.

RIGHT TO RECOVER PAYMENTS MADE IN ERROR

The University of South Alabama has the right to recover any benefit amount paid in error, in excess of Plan benefit limitations or due to failure of the Member to provide timely information concerning eligibility.

If incorrect payments are made to you or to a medical provider, the amount of the overpayment must be refunded, or it will be deducted from any future payment to you or the provider. The Claims Administrator is authorized and empowered to recover payments made in error by any appropriate method, including legal action for collection.

RECEIPT OF PAYMENT SATISFIES OBLIGATION

The Claims Administrator’s agreement with some providers requires the Plan to pay benefits directly to them. On all other claims, the Plan may choose at its option to pay either you or the provider. You may assign benefits to a provider and the Plan will pay directly to the provider. Payment to you or the provider will be considered to satisfy the Plan’s obligation to you. The Plan does not have to honor any assignment of your claim to anyone, including a provider. If you die, become incompetent, or are a minor, the Plan will pay your estate, your guardian or any relative that in the Plan’s judgment is entitled to the payment. Payment of benefits to one of these in all cases will satisfy the Plan’s obligation to you.
HOW TO FILE A CLAIM FOR BENEFITS

In all cases, you should file a written claim with the Claims Administrator listed below within 90 days of incurring charges. Failure to file a claim for benefits within 12 months of the date the expense was incurred will result in denial of benefits. Claim forms are available from the University of South Alabama Human Resources Department.

It is very important that you show your Blue Cross Blue Shield and Express Scripts identification cards to your medical providers to ensure proper filing of your claims. You must show your Express Scripts identification card at the pharmacy and at your doctor’s office.

Generally your medical provider will file direct with the claims administrators.

There may be a situation where you need to file a paper claim or seek assistance with filing a claim for benefit(s). In such case the claim or inquiry should be directed to –

PHARMACY

Express Scripts
P.O. Box 66568
St Louis, MO  63166-6568
1-855-687-3857

MEDICAL & DENTAL

Blue Cross Blue Shield of Alabama
450 Riverchase Parkway East
Birmingham, AL  35244-2858
1-877-345-6171

In all cases, the Member is responsible for ensuring that the claim has been filed in a timely manner.

You may also contact the University of South Alabama Human Resources Department:

University of South Alabama Campus........460-6133
USA Medical Center .................................471-7325
USA Children’s and Women’s Hospital......415-1604

DELEGATION OF AUTHORITY

The USA Health & Dental Plan has delegated to Blue Cross Blue Shield of Alabama, the Claims Administrator, the discretionary responsibility and authority to determine claims under the Plan, to construe, interpret and administer the Plan, and to perform every other act necessary or appropriate in connection with the provision of administrative services. When the Claims Administrator makes reasonable determinations that are neither arbitrary nor capricious in administration of the Plan, those determinations will be final and binding upon the Members, subject only to the appeals procedure and University review procedure as explained in this booklet, and thereafter to judicial review to determine whether the determination was arbitrary or capricious. No legal action may be commenced against the Plan or the University of South Alabama individually or collectively, more than one year after the date of the USA Health & Dental Plan Management Committee’s final decision.

RELATIONSHIP OF PARTIES

The relationship between the University of South Alabama, the USA Health & Dental Plan, Network providers and the Claims Administrator are independent contractor relationships. Network providers and the Claims Administrator are not agents or employees of the University or the USA Health & Dental Plan.

Neither the University nor the USA Health & Dental Plan is liable for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by the Member while receiving care from any Network Provider or any other provider.

Notwithstanding any statement herein to the contrary, the University of South Alabama does not waive any sovereign immunity provided by state and federal constitutions, or other laws or provisions of law. The agent for the service of legal process shall be the Claims Administrator.
COBRA CONTINUATION OF COVERAGE

A federal law, the Consolidated Omnibus Budget Reconciliation Act (COBRA), allows former employees and dependents to continue their health coverage under this Plan in certain circumstances beyond the date on which their coverage would otherwise have ceased. If COBRA applies, you may be able to temporarily continue coverage under the Plan beyond the point at which coverage would otherwise end because of a life event known as a “qualifying event.” After a qualifying event, COBRA coverage may be offered to each person who is a “qualified beneficiary.” You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of a qualifying event.

By law, COBRA benefits are required to be the same as those made available to similarly situated active employees. You are required to pay for coverage. Your cost will equal the full cost of the coverage plus a two percent administrative fee. Your cost may change over time, as the cost of benefits under the Plan changes.

COBRA RIGHTS FOR EMPLOYEES: If you are an Eligible Employee, you will become a qualified beneficiary if you lose coverage under the Plan because either one of the following qualifying events happens: (1) your hours of employment are reduced, or (2) your employment ends for any reason other than your gross misconduct.

COBRA coverage will continue for up to a total of 18 months from the date of your termination of employment or reduction in hours, assuming you pay your premiums on time. If, apart from COBRA, the University continues to provide coverage to you after your termination of employment or reduction in hours (regardless of whether such extended coverage is permitted under the Plan), the extended coverage you receive will ordinarily reduce the time period over which you may purchase COBRA benefits.

If you are on a leave of absence covered by the Family and Medical Leave Act (FMLA), and you do not return to work, you will be given the opportunity to buy COBRA coverage. The period of your COBRA coverage will begin when you fail to return to work following the expiration of your FMLA leave or you inform your employer that you do not intend to return to work, whichever occurs first.

DEPENDENT COBRA RIGHTS: If you are covered under the Plan as a spouse or a dependent child, you will become a qualified beneficiary if you would otherwise lose coverage under the Plan as a result of any of the following events: (1) the Employee dies; (2) the Employee’s hours of employment are reduced; (3) the Employee’s employment ends for any reason other than gross misconduct; (4) the Employee becomes enrolled in Medicare; or (5) divorce of the Employee and spouse; or (6) the dependent child loses dependent child status under the Plan.

When the qualifying event is a divorce or a child losing dependent status under the plan, you must timely notify the Human Resources Department of the qualifying event. You must provide this notice within 60 days of the event or within 60 days of the date on which coverage would be lost because of the event, whichever is later.

If you are a covered spouse or dependent, the period of COBRA coverage will generally last up to a total of 18 months in the case of a termination of employment or reduction in hours and up to a total of 36 months in the case of other qualifying events, provided that premiums are paid on time.

If, however, the covered employee became enrolled in Medicare before the end of employment or a reduction in hours, COBRA coverage for the covered spouse and dependent children will continue for up to 36 months from the date of Medicare enrollment or 18 months from the date of termination of employment or a reduction in hours, whichever period ends last.

If you are a child of the covered employee or former employee and you are receiving benefits under the plan pursuant to a Qualified Medical Child Support Order, you are entitled to the same COBRA rights as a dependent child of the covered employee.

If your spouse cancels your coverage in anticipation of divorce and a divorce later occurs, your divorce may be a qualifying event even though you actually lost coverage under the Plan earlier. If you timely notify the Human Resources Department of your divorce and can establish that your spouse canceled your coverage in anticipation of divorce, COBRA coverage may be available to you beginning on the date of your divorce (but not for the period between the date your coverage ended and the divorce date).
EXTENSION OF COVERAGE FOR DISABILITY: In certain circumstances you can take advantage of a disability extension. If a Member is or becomes disabled under Title II (OASDI) or Title XVI (SSI) of the Social Security Act and timely notice is given to the Human Resources Department, the 18-month period of COBRA coverage for the disabled person may be extended to up to 11 additional months (for a total of up to 29 months) or the date the disabled person becomes covered by Medicare, whichever occurs sooner. This 29-month period also applies to any non-disabled family members who are receiving COBRA coverage, regardless of whether the disabled individual elects the 29-month period for him or herself. The 29-month period will run from the date of the termination of employment or reduction in hours. For this disability extension to apply, the disability must have started at some time before the 60th day of COBRA coverage and must last at least until the end of the 18-month period of COBRA coverage.

The cost for COBRA coverage after the 18th month will be 150% of the full cost of coverage under the Plan, assuming that the disabled person elects to be covered under the disability extension. If the only persons who elect the disability extension are non-disabled family members, the cost of coverage will remain at 102% of the full cost of coverage.

For spouses and children, the disability extension may be further extended to 36 months if another qualifying event (death, divorce, enrollment in Medicare, or loss of dependent status) occurs during the 29-month period. See the following discussion under “Extension of COBRA for a Second Qualifying Event” for additional information.

For this disability extension of COBRA coverage to apply, you must give the Human Resources Department timely notice of Social Security’s disability determination before the end of the 18-month period of COBRA coverage and within 60 days after the later of (1) the date of the initial qualifying event, (2) the date on which coverage would be lost because of the initial qualifying event, or (3) the date of Social Security’s determination. You must also notify the Human Resources Department within 30 days of any revocation of Social Security disability benefits. See the section below titled “Notice Procedures” for additional information.

EXTENSION OF COBRA FOR SECOND EVENT: In certain circumstances spouses and children can take advantage of a special second qualifying event extension. A spouse and children receiving COBRA coverage may have the 18-month period extended to 36 months if another qualifying event occurs during the 18-month period, if you give the Human Resources Department timely notice of the second qualifying event. The 36-month period will run from the date of the termination of employment or reduction in hours. This extension is available to a spouse and children receiving COBRA coverage if the covered Employee or former Employee dies, becomes enrolled in Medicare (under Part A, Part B, or both), or gets divorced, or if the child stops being eligible under the plan as an Eligible Dependent, but only if the event would have caused the spouse or child to lose coverage under the plan had the first qualifying event not occurred. For example, if an Eligible Employee is terminated from employment, elects family coverage under COBRA, and then later enrolls in Medicare, this second event will rarely be a second qualifying event that would entitle the spouse and children to extended COBRA coverage. This is so because, for almost all plans that are subject to COBRA, this event would not cause the spouse or dependent children to lose coverage under the Plan if the covered employee had not been terminated from employment.

For this 18-month extension to apply, you must give the Human Resources Department timely notice of the second event within 60 days after the event occurs or within 60 days after the date on which coverage would be lost, whichever is later.

NOTICE PROCEDURES: If you do not follow these notice procedures or if you do not give the Human Resources Department notice within the required 60-day notice period, you will not be entitled to COBRA or an extension of COBRA as a result of an initial qualifying event of divorce or loss of dependent child status, a second qualifying event or Social Security’s disability determination.

Any notices of initial qualifying events of divorce or loss of dependent child status, second qualifying events or Social Security disability determinations that you give must be in writing. Your notice must be received by the Human Resources Department no later than the last day of the required 60-day notice period unless you mail it. If mailed, your notice must be postmarked no later than the last day of the required 60-day notice period.
For your notice of an initial qualifying event that is a divorce or a child losing dependent status under the Plan and for your notice of a second qualifying event, you must mail or hand deliver your notice to the Human Resources Department:

University of South Alabama  
650 Clinic Drive  
Technology & Research Park  
Building III, Suite 2200  
Mobile, AL  36688

If the initial or second qualifying event is a divorce, your notice must include a copy of the divorce decree. For your convenience, you may ask the Human Resources Department for a copy of the Notice by Qualified Beneficiaries form that you may use to give your notice.

The written notice of Social Security’s disability entitlement determination must be filed with the Human Resources Department for you to qualify for an extension. You may also use the Notice by Qualified Beneficiaries form for your convenience.

ADDING NEW DEPENDENTS TO COBRA:  
You may add new dependents to your COBRA coverage under the same eligibility rules that apply to Eligible Employees. In addition, except as explained below, any new dependents that you add to your coverage will not have independent COBRA rights. That means, for example, that if you die, they will not be able to continue coverage.

If you are the covered employee and you acquire a child by birth or placement for adoption while you are receiving COBRA coverage, then your new child will have independent COBRA rights. This means that if you die, for example, your child may elect to continue receiving COBRA benefits for up to 36 months from the date on which your COBRA benefits began.

If your new child is disabled within the 60-day period beginning on the date of birth or placement of adoption, the child may elect coverage under the disability extension if you timely notify the Human Resources Department of Social Security’s disability determination as explained above. The election should be made on the child’s behalf by the child’s legal guardian.

MEDICARE AND COBRA COVERAGE:  
You should consider whether it is beneficial to purchase COBRA coverage. After you retire or have another qualifying event under COBRA, your COBRA coverage will be secondary to Medicare with respect to services or supplies that are covered, or would be covered under Medicare. This means that, regardless of whether you have enrolled in Medicare (Part A or Part B), your COBRA coverage after such qualifying event will not cover most of your hospital, medical and prescription drug expenses.

If you think you will need both Medicare and COBRA, you should enroll in Medicare (Part A and Part B) on or before the date on which you make your election to buy COBRA coverage. If you do this, COBRA coverage for your dependents will continue for a period of 18 months from the date of your retirement or 36 months from the date of your Medicare enrollment, whichever period ends last. Your COBRA coverage will continue for a period of 18 months. If you do not enroll in Medicare on or before the date on which you make your election to buy COBRA coverage, your COBRA benefits will end when your Medicare coverage begins. Your covered dependents will have the opportunity to continue their own COBRA coverage.

If you do not want both Medicare and COBRA, your covered family members will still have the option to buy COBRA. However, if your covered family members become enrolled in Medicare after electing COBRA, their COBRA coverage will end.

ELECTING COBRA:  
After the Human Resources Department receives timely notice that a qualifying event occurred, the Human Resources Department is responsible for (1) notifying you that you have the option to buy COBRA, and (2) sending you an application to buy COBRA coverage.

You have 60 days to elect to buy COBRA coverage. The 60-day period begins to run from the later of (1) the date you would lose coverage, or (2), the date on which the Human Resources Department notifies you that you have the option to buy COBRA.

Each qualified beneficiary has an independent right to elect COBRA. You may elect COBRA on behalf of your spouse, and parents may elect COBRA coverage on behalf of their children. An election to buy COBRA coverage will be considered made on the date the application is received by the Human Resources Department.
Once the Human Resources Department has notified the Claims Administrator that your coverage under the Plan has ceased, the Claims Administrator will retroactively terminate your coverage and rescind payment of claims incurred after the date coverage ceased. If you elect to buy COBRA during the 60-day election period, and if your premiums are paid on time, the Claims Administrator will retroactively reinstate your coverage and process claims incurred during the 60-day election period.

Because there may be a lag between the time your coverage under the Plan ends and the time the Claims Administrator learns of the loss of coverage, it is possible that claims incurred during the 60-day election period may be paid. If this happens, you should not assume that you have coverage. The only way your coverage will continue is if you elect to buy COBRA and pay your premiums on time.

**COBRA PREMIUMS:** Your first COBRA premium must be made no later than 45 days after you elect COBRA. That payment must include all premiums owed from the date on which COBRA began. This means that your first premium could be larger than the monthly premium that you will be required to pay going forward. You are responsible for making sure the amount of your first payment is correct. You may contact the Human Resources Department to confirm the correct amount of your first payment.

**EARLY TERMINATION OF COBRA COVERAGE:** Your COBRA coverage will terminate early if any of the following events occurs: (1) the University no longer provides group health coverage to any of its Employees; (2) you do not pay the premium for your continuation coverage on time; (3) after electing COBRA coverage, you become covered under another group health plan; (4) after electing COBRA coverage, you become enrolled in Medicare; or, (5) you are covered under the additional 11-month disability extension and there has been a final determination that the disabled person is no longer disabled for Social Security purposes.

In addition, COBRA coverage can be terminated if otherwise permitted under the terms of the Plan. For example, if you submit fraudulent claims, your coverage will terminate.

**MARKETPLACE OPTION:** Instead of enrolling in COBRA continuation coverage, there may be other more affordable coverage options for you and your family through the Marketplace, Medicaid, or other group health plan coverage options (such as a spouse’s plan) through what is called a “special enrollment period.” Some of these options may cost less than COBRA.

The Marketplace offers “one-stop shopping” to find and compare private health insurance options. In the Marketplace, you could be eligible for a tax credit that lowers your monthly premiums.

Through the Marketplace you’ll also learn if you qualify for free or low-cost coverage from Medicaid or the Children’s Health Insurance Program (CHIP). You can access the Marketplace for your state at [www.HealthCare.gov](http://www.HealthCare.gov), or call 1-800-318-2596.

Coverage through the Marketplace may cost less than COBRA continuation coverage. Being offered COBRA continuation coverage won’t limit your eligibility for coverage or for a tax credit through the Marketplace.

Once you’ve exhausted your COBRA coverage and coverage terminates, you may be eligible to enroll in Marketplace coverage through a special enrollment period, even if the Marketplace open enrollment has ended. If you sign up for Marketplace coverage instead of COBRA, you cannot switch to COBRA continuation coverage under any circumstances.

**FAMILY AND MEDICAL LEAVE**

You may be eligible for family and/or medical leave and to continue health coverage if you have been employed for at least 12 months, and have worked a minimum of 1,040 hours during the 12 month period immediately preceding the commencement of the leave.

If you become eligible for a family and/or medical leave in accordance with the Family and Medical Leave Act of 1993 (FMLA), your health coverage may be continued for a maximum of 90 days during a 12 month period, for any of the following reasons:

1. To care for your child after birth or placement of a child with you for adoption or state-action foster care; so long as such leave is completed within 12 months after the birth or placement of the child.
2. To care for your spouse, child, stepchild or parent who has a serious health condition.

3. Your own serious health condition.

Under FMLA, a “serious health condition” involves inpatient Hospital treatment, continuing treatment by a medical provider and a period of incapacity for more than three (3) days. Examples of conditions not considered to be “serious health conditions” include Cosmetic treatments (unless there are complications), routine office visits, and common ailments without complications such as colds, flu, earaches, headaches and upset stomachs. Pregnancy is considered a “serious health condition” for the purpose of FMLA.

To qualify for continuation of health and dental coverage under FMLA, you must notify your immediate supervisor of your intention to take an FMLA leave, not less than 30 days in advance of a foreseeable leave.

To continue coverage during your FMLA leave, you must continue to pay the Employee Contribution.

You and your Eligible Dependents are subject to all provisions and limitations of the Plan during your leave; anything in conflict with the provisions of the FMLA will be construed in accordance with the FMLA. If there are any changes to the Plan during your leave, you will be notified in writing.

Continuation of coverage under FMLA terminates the earlier of:

1. The date you return to work.
2. The date you notify your supervisor you are not returning to work, in which case this date will be considered your COBRA qualifying event.
3. The first day of the month for which you fail to make payment of the Employee Contribution within a 30-day grace period.
4. The date coverage has been continued for a maximum of 90 days, in which case this date will be considered your COBRA qualifying event.

If you are considering FMLA leave, or believe you qualify for FMLA leave, you should contact your supervisor and the Human Resources Department for additional information.

UNIFORMED SERVICES LEAVE

Commonly referred to as USERRA, the Uniformed Services Employment and Reemployment Rights Act applies to Employees who perform duty in the Uniformed Services.

Uniformed Service includes active duty, active duty training, inactive duty training, and any time away from employment for the purpose of an examination to determine fitness for duty.

Employees who will be absent from employment for more than 30 days due to Uniformed Services duty may elect to continue coverage for themselves and their Eligible Dependents for up to 24 months. Employees who will be absent for less than 30 days will have their coverage continued under the same provisions as if they had remained under active employment.

If you are eligible for rights under USERRA, you must follow the procedure provided below:

1. Notify the Human Resources Department that you are leaving your job for temporary duty in the Uniformed Services. You may notify the Human Resources Department verbally or in writing, but you must do so in advance of leaving employment unless it is an emergency call-up or impossible by military necessity.

2. Notify the Human Resources Department of your intention to continue your health and dental coverage under USERRA. You will be notified in writing of the required Employee Contribution to maintain coverage under the Plan.

3. Make arrangements to pay monthly, or make payment in advance of the required Employee Contribution to maintain coverage.

In the event you choose not to pay the Employee Contribution (COBRA rate) during your leave, your coverage will not be continued during the leave. Following your discharge from Uniformed Service, you may be eligible to apply for re-employment in accordance with USERRA.

You will be able to reinstate your coverage on the day you return to work, subject to all provisions of the Plan in effect at the time coverage reinstates.
USERRA continuation coverage terminates the earlier of:

1. The date you return to work.
2. The date you notify your supervisor you are not returning to work, in which case you may be eligible to continue coverage for any COBRA period remaining.
3. The first day of the month for which you fail to make payment of the required Employee Contribution within a 30-day grace period.
4. The date coverage has been continued for a maximum of 24 months.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

This Plan will, under certain circumstances, provide coverage for children named in a court order as your dependents. If you receive such an order, in cases of divorce or assignment of paternity, it should be submitted to the Human Resources Department for review to determine that it is a Qualified Medical Child Support Order (QMCSO).

A QMCSO is a judgment, decree or order, including approval of a settlement agreement, issued by a court of competent jurisdiction or administrative agency which:

1. Relates to health benefits and provides for the named child(ren)’s health benefit coverage under the Employee’s plan of benefits, pursuant to a state domestic relations law, community property law, or enforcement of a law relating to medical child support as described in Section 1908 of the Social Security Act;
2. Creates or recognizes the existence of the named child(ren)’s right to be enrolled and receive medical benefits under the Employee’s plan of benefits;
3. States the period to which the order applies;
4. States the name and last known mailing address of the Employee and each child covered by the order; and
5. Does not require this Plan to provide any type or form of benefit or any option not otherwise provided by the Plan.

A medical child support order must be filed with the Human Resources Department within 30 days of the date of the order to be considered by the Plan. When the Human Resources Department receives a medical child support order, the order will be reviewed to determine if it meets the definition of a QMCSO. Within 30 days of receipt of the order, or within a reasonable time thereafter, written notice will be provided to the Employee of the Plan’s decision. This notice will also be sent to the other party or representative named in the order.

If a determination is made that the order is not qualified, the notice will provide the specific reasons for that decision and the opportunity to correct the order or appeal the decision.

If a determination is made that the order is a QMCSO, the notice will provide instructions for enrolling each child named in the order, and the Plan provisions, limitations and exclusions that apply. The University will impose a payroll deduction for Dependent Coverage, if applicable.

This will be considered a Change-In-Status Event for the purpose of enrolling the child(ren) with an Effective Date the first of the month following the date of the QMCSO.

As part of its authority, the Plan has the discretion to decide if an order meets or does not meet the definition of a QMCSO, and the decision will be binding and conclusive on all persons.

PRIVACY NOTICE

The confidentiality of your health information is important to us. Under a federal law called the Health Insurance Portability and Accountability Act of 1996 (HIPAA), plans such as this one are generally required to limit the use and disclosure of protected health information to treatment, payment, and healthcare operations and to put in place appropriate safeguards to protect your protected health information. This section explains some of HIPAA’s requirements. Additional information is contained in the plan’s notice of privacy practices. You may request a copy of this notice by contacting the Human Resources Department.
Disclosures of Protected Health Information:

In order for your benefits to be administered, the Plan may need to share protected health information with the Employer. Following are circumstances under which the Plan may disclose your protected health information to the Employer:

• The plan may inform the Employer whether you are enrolled in the Plan.

• The Plan may disclose summary health information to the Employer. The Employer must limit its use of that information to obtaining quotes from insurers or modifying, amending, or terminating the Plan. Summary health information is information that summarizes claims history, claims expenses, or types of claims without identifying you.

• The Plan may disclose your protected health information to the Employer for administrative purposes. This is because employees of the Employer perform some of the administrative functions necessary for the management and operation of the Plan.

Following are the restrictions that apply to the Employer's use and disclosure of your protected health information:

• The Employer will only use or disclose protected health information for Plan administrative purposes, as required by law, or as permitted under the HIPAA regulations.

• If the Employer discloses any of your protected health information to any of its agents or subcontractors, the Employer will require the agent or subcontractor to keep your protected health information as required by the HIPAA regulations.

• The Employer will not use or disclose your protected health information for employment-related actions or decisions or in connection with any other benefit or benefit plan.

• The Employer will promptly report to the Plan any use or disclosure of your protected health information that is inconsistent with the uses or disclosures allowed in this section of this booklet.

• The Employer will allow you or the Plan to inspect and copy any protected health information about you that is in the Employer's custody and control. The HIPAA regulations set forth the rules that you and the plan must follow in this regard. There are some exceptions.

• The Employer will amend, or allow the Plan to amend, any portion of your protected health information to the extent permitted or required under the HIPAA regulations.

• With respect to some types of disclosures, the Employer will keep a disclosure log. The disclosure log will go back for six years. You have a right to see the disclosure log. The Employer does not have to maintain the log if disclosures are for certain Plan related purposes, such as payment of benefits or healthcare operations.

• The Employer will make its internal practices, books, and records, relating to its use and disclosure of your protected health information available to the Plan and to the U.S. Department of Health and Human Services, or its designee.

• The Employer will, if feasible, return or destroy all of your protected health information in the Employer's custody or control. If it is not feasible for the Employer to return or destroy your protected health information, the Employer will limit the use or disclosure of any protected health information that it cannot feasibly return or destroy to those purposes that make return or destruction of the information infeasible.

Following are restrictions that will apply to the Employer's use and disclosure of your protected health information in accordance with the HIPAA regulations that have just been explained.

If any of the foregoing employees or workforce members of the Employer use or disclose protected health information in violation of the rules that are explained above, the employees or workforce members will be subject to disciplinary action and sanctions – which may include termination of employment. If the Employer becomes aware of any such violation, the Employer will promptly report the violation to the Plan and will cooperate with the Plan to correct the violation, to impose appropriate sanctions, and to relieve any harmful effects to you.

Security of Your Personal Health Information:

Following are restrictions that will apply to the Employer's storage and transmission of your electronic protected health information:
The Employer will have in place appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of your electronic protected health information, as well as to ensure that only those employees or other workforce members of the Employer have access to use or disclose your protected health information in accordance with the HIPAA regulations.

If the Employer discloses any of your electronic protected health information to any of its agents or subcontractors, the plan sponsor will require the agent or subcontractor to have in place the appropriate safeguards as required by the HIPAA.

The Employer will report to the plan any security incident of which it becomes aware in accordance with the HIPAA regulations.

**Use and Disclosure of Your Personal Health Information:**

As a business associate of the Plan, Blue Cross Blue Shield of Alabama and Express Scripts, Inc. have an agreement with the Plan that allows us to use your personal health information for treatment, payment, healthcare operations, and other purposes permitted or required by HIPAA.

In addition, by applying for coverage and participating in the Plan, you agree that we may obtain, use and release all records about you and your dependents that we need to administer the Plan or to perform any function authorized or permitted by law. You further direct all persons to release all records to us about you and your dependents that we need in order to administer the Plan.

**ANNUAL FEDERAL NOTICES**

Each year the Plan sends to all participants the Annual Federal Notices. New employees receive this notice with enrollment information. Contained in the Annual Federal Notices:

- Medicare Creditable Drug Coverage Notice
- Information on the Affordable Care Act including the Summary of Benefits and Coverage
- Where to obtain Privacy Policies
- Children’s Health Insurance Program Notice
- Information on the University’s “opt-out” of certain federal acts and the affect that action has on benefits including:
  - Mental Health Parity Act of 1996 and Mental Health Parity and Addiction Equity Act of 2008
  - Health Insurance Portability & Accountability Act
  - Newborns’ and Mothers’ Health Protection Act
  - Women’s Health and Cancer Rights Act
  - Michelle’s Law

A copy of the notice and other required notice such as the Privacy Policy may be obtained from –
University of South Alabama
Human Resources Department
Technology & Research Park
650 Clinic Drive
Building III, Suite 2200
Mobile, AL 36688
(251) 460-6133

**GRANDFATHERED STATUS – ACA**

The Plan is a “grandfathered plan” under the Affordable Care Act (ACA). As permitted by the Act, a grandfathered plan may preserve certain basic health coverage that was already in effect when that law was enacted. As a grandfathered health plan, the Plan may not include certain consumer protections of the Act that apply to other plans; for example, the requirement for the provision of preventive health services without any cost sharing. However grandfathered health plans must comply with certain other consumer protections in the Act; for example the elimination of lifetime limits on benefits. Questions regarding which protections apply and do not apply and what might cause a plan to change its status may be directed to the Human Resources Department. You may contact the US Department of Health and Human Services at healthreform.gov.

**THE PLAN’S OPT-OUT OF SOME FEDERAL REGULATIONS**

The Plan has elected to opt-out of certain federal regulations including: the Health Insurance Portability & Accountability Act of 1996 (HIPAA), as amended by the Affordable Care Act; the Newborns’ & Mothers’ Health Protection Act of 1996 (NMHPA); the Mental Health Parity Act of 1996 (MHPA); the Mental Health Parity & Addiction Equity Act of 2008; and Michelle’s Law (2008). The Plan does comply with the HIPAA provisions for special enrollment rules and the discrimination based on health status rules.
USING PRE-TAX DOLLARS FOR EXPENSES

The University of South Alabama and USA HealthCare Management, LLC sponsor an employee benefit program for Employees known as a Health and Dependent Care Flexible Spending Account (SouthFlex). SouthFlex allows you to set aside a certain amount each year, pretax, for health-related and dependent care expenses not reimbursed by any other program or plan. You then use those pre-tax dollars to reimburse yourself for out-of-pocket health and dependent care expenses. Participation in SouthFlex is voluntary.

Under SouthFlex, your contribution will be deducted from your pay before taxes and deposited into your account. This arrangement helps you because the amounts you elect for deduction are nontaxable; you save Social Security and income taxes on the amount of your salary reduction.

This is only a summary of SouthFlex. You can obtain additional information and forms on the website at www.HealthEquity.com and info@healthequity.com or call 1-877-288-0719.

PARTICIPATION IN THE PLAN

You may participate in SouthFlex if you are an Employee. You do not have to enroll in the USA Health & Dental Plan to participate in SouthFlex.

During the Open Enrollment Period, usually the month of November, you may complete an election form determining the amount you wish to contribute to your SouthFlex account beginning the first of the following year.

The amount you elect to contribute must be in whole dollars and will be divided equally depending on your pay schedule. This amount will be deducted from your pay before taxes are withheld and deposited into your spending account.

You may direct up to a maximum amount allowed each year (the maximum is set by the Internal Revenue Service) to your SouthFlex account to pay for eligible health care expenses. The maximum may change annually based on the amount set by the Internal Revenue Service. The minimum annual election is $100.

You may direct up to a maximum of $5,000 to your SouthFlex account each year to pay for dependent day care expenses so you (and, if married, your spouse) can work outside the home or attend school full-time. Unpaid volunteer work or volunteer work for a nominal salary does not qualify as work outside the home.

If you and your spouse file income taxes separately, the most either of you can put into the program to pay for dependent day care expenses is $2,500.

USE IT OR LOSE IT POLICY

The Flexible Spending Account can save you money by using pre-tax dollars, and can benefit you by allowing you to save for health care expenses that are not covered by your Plan. However, the amount you choose to contribute requires careful planning. **Money you contribute to your SouthFlex account must be used during the Calendar Year.** Money left in an account does not carry over to the next year, and is not refundable at the end of the year. In other words, if you do not use it, you will lose it.

Funds assigned to the health care Flexible Spending Account cannot be transferred to the dependent care Flexible Spending Account under any circumstances. Funds assigned to the dependent care Flexible Spending Account cannot be transferred to the health care Flexible Spending Account under any circumstances.

GRACE PERIOD FOR “USE IT OR LOSE IT” RULE

There is a grace period for the Health flexible spending account only (this rule does not apply to expenses under the dependent care flexible spending account).

Money remaining in the health flexible spending account at the end of the Calendar Year may be carried over and used to cover eligible expenses incurred through March 15th of the next Calendar Year. This is referred to as a grace period.

This does not eliminate the “use it or lose it” rule altogether. Any unused amounts from the prior Calendar Year that are not used to reimburse expenses by the end of the grace period must be forfeited.
COORDINATION WITH HEALTH & DENTAL PLAN

SouthFlex is administered by HealthEquity, Inc., and is coordinated with the USA Health & Dental Plan. Out-of-pocket expenses for Eligible Employees and their Eligible Dependents (such as Copays and Deductibles) will automatically apply to your SouthFlex account. In addition, you will be able to file for reimbursement of qualified non-Covered Services.

ELIGIBLE HEALTH CARE EXPENSES

SouthFlex can be used to reimburse you for your own health care expenses, as well as those of your Eligible Dependents, as long as the expenses are:

1. amounts paid for “medical care” as described in Internal Revenue Code Section 213(d);
2. not reimbursable under any other health plan in which you participate; and
3. incurred after the date of your enrollment and during the Calendar Year; however, if your employment terminates during the Calendar Year, health care expenses must be incurred before your termination date (unless you elect continuation of coverage under COBRA).

Expenses eligible under the SouthFlex program are those not paid in full under any health care plan in which either you or your Eligible Dependents participate, including Deductibles, Copays and fees over the Allowed Amount. Eligible expenses do not include health, dental or life insurance premiums.

Following are examples of health care expenses that are reimbursable by SouthFlex. This is a partial list extracted from IRS publications and is subject to change. Eligible health care expenses include:

- acupuncture
- ambulance transportation expenses
- artificial limbs - artificial teeth
- birth control pills
- car controls for handicapped
- chiropractors
- contact lenses
- crutches
- drug and alcohol addiction treatment
- eyeglasses, eye exams, and laser eye surgery
- fertility enhancement
- guide dogs
- hearing aids and hearing aid batteries
- lead-based paint removal
- learning disability tuition
- nursing services
- optometrists
- special schools for the handicapped
- surgery (other than cosmetic surgery)
- therapy (medical)
- transportation to/from health care provider
- weight-loss plans prescribed by a physician to treat a specific disease
- wheelchairs

For a more complete list of eligible expenses, consult your personal tax advisor or refer to IRS publication 502, Medical and Dental Expenses which contains a list of deductible expenses. This publication can be obtained through your local IRS office or on the web at –


NOTE: Misuse of spending account funds is a violation of Internal Revenue Service regulations.

HEALTH CARE EXPENSES THAT ARE NOT ELIGIBLE FOR REIMBURSEMENT

Although the Health Flexible Spending Account covers a wide variety of health care expenses, there are some expenses that are not eligible for payment. For example, expenses you incur in connection with activities that are merely beneficial to your general health and not directly related to specific health care are not reimbursable. And, as already noted, eligible expenses do not include health, dental, or life insurance premiums. Other types of health care that are not eligible include:

1. expenses incurred for health clubs, spas and weight loss programs (unless prescribed by a physician solely for the purpose of treating an illness or accident);
2. expenses for which you receive benefits from any health, dental, vision or other health care plan;
3. most kinds of cosmetic health services and supplies (unless medically necessary and not covered by a health plan), hair transplants, electrolysis, and teeth whitening; and,
4. dietary and herbal supplements such as vitamins, fiber, and minerals (unless prescribed by a physician solely for the purpose of treating an illness).

Expenses are eligible for reimbursement from the FSA only if they are expenses paid for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body.
ELIGIBLE DEPENDENT CARE EXPENSES

SouthFlex can be used to reimburse you for your dependent expenses, as long as the expenses are:

1. incurred so that you and your spouse (if you are married) can work or attend school full-time;
2. incurred for services relating to the care of a child under the age of 13, or your Disabled child or adult who lives with the employee for more than half of the taxable year;
3. incurred after the date of your enrollment and during the Calendar Year; however, if your employment terminates during the Calendar Year, dependent care expenses must be incurred before termination.

Following are examples of dependent care expenses that are reimbursable by SouthFlex. Eligible dependent care expenses include:

1. expenses incurred for dependent day care that allow you (and if married, your spouse) to work or attend school full-time;
2. licensed nursery school or day care center for children, provided the facility complies with all applicable state and local laws and regulations, provides care for six or more individuals, and receives a fee for providing day care services;
3. costs for dependent care services in or outside your home;
4. costs for household services which are in part attributable to the care of the dependent.

For expenses to be eligible for reimbursement, the person you pay to provide care for your dependents cannot be your spouse, another dependent, or a family member under the age of 19.

For more information about eligible dependent care expenses, refer to IRS Publication 503, Child and Dependent Care Credit, which can be obtained at your local IRS office or on the web at –


DEPENDENT CARE EXPENSES THAT ARE NOT ELIGIBLE FOR REIMBURSEMENT

Certain dependent care expenses are not covered under SouthFlex. Examples of ineligible expenses include, but are not limited to:

1. any amounts you pay to a family member under the age of 19 or any person you claim as a dependent on your federal income tax return;
2. costs for any person caring for your dependents when you or your spouse are not working;
3. transportation not provided by a care provider;
4. child support payments;
5. education expenses for kindergarten and above or overnight camp expenses;
6. food, clothing and entertainment;
7. cleaning and cooking services not provided by the care provider.

REIMBURSEMENT PROCEDURE

If you (or your health care provider) file a primary health or dental claim with the Claims Administrator and no secondary coverage is reflected on your contract, it will not be necessary to file for reimbursement of any non-paid amount. These non-paid health expenses will automatically be filed and processed under your Health FSA if the funds are available (minimum reimbursement amount is $10).

For other eligible expenses, you must file a Request for Reimbursement.


Fill it out and attach Explanation of Benefits (EOB) forms, bills, invoices, receipts, or other supporting statements showing the amount of the health-related expenses or dependent care expenses for which you are claiming reimbursement. Send the Request for Reimbursement form and attachments to –

HealthEquity, Inc.
15 West Scenic Pointe Drive, Suite 100
Draper, UT 84020
info@healthequity.com
www.HealthEquity.com

If HealthEquity receives a submission that does not qualify as a Request for Reimbursement, it will notify you of the additional information needed.

Requests for Reimbursement for eligible health care and eligible dependent care expenses incurred in a Calendar Year must be submitted by the close of the timely filing period. April 15th of the following Calendar Year. After the close of that period any money in the account is forfeited unless subject to a properly filed Request for Reimbursement or appeal.
The University of South Alabama and USA HealthCare Management, LLC sponsor an employee benefit program for Employees known as a Section 125 Premium Conversion Plan. The purpose of the Plan is to increase your spendable income by reducing your taxes. Current tax legislation allows employers to offer Employees the benefit of having their Employee Contribution for qualified benefit plans deducted from their paychecks before taxes are taken out.

Under the Premium Conversion Plan, your cost will still be deducted from your paycheck. The difference is that your cost will be deducted from your pay before taxes. This arrangement helps you because the benefits you elect are nontaxable; you save Social Security and income taxes on the amount of your salary reduction.

PARTICIPATION IN THE PLAN

You may participate in the Section 125 Premium Conversion Plan if you are an Eligible Employee. You will become a participant in the Section 125 Premium Conversion Plan at the time you enroll in the USA Health & Dental Plan.

Alternatively, you can pay for the same benefit with after-tax dollars on a salary deduction basis. If you elect not to participate in the plan, after-tax premium coverage will be funded by an amount deducted from your compensation which is sufficient to pay for the coverage after withholding any applicable federal, state, or Social Security taxes.

BENEFITS OFFERED

The Section 125 Premium Conversion Plan permits you to pay your Employee Contribution for the USA Health & Dental Plan with pre-tax dollars through salary reduction rather than regular pay.

Since Social Security taxes are not withheld from Employee Contributions paid under the Section 125 Premium Conversion Plan, your Social Security retirement benefit may be slightly reduced.

CHANGE OF ELECTION

You may change your election for pre-tax premiums only during the Open Enrollment Period, which is usually the month of November each year, and then only for the coming Calendar Year. There is an important exception to this general rule: You may change or revoke your previous election for pre-tax premiums at any time during the Calendar Year due to a Change-In-Status Event as explained in this Member Handbook.

TERMINATION OF EMPLOYMENT

If your employment with the University of South Alabama is terminated during the Calendar Year, your active participation in the Section 125 Premium Conversion Plan will cease, and you will not be able to make any more contributions to the plan, other than as may be permitted under the COBRA continuation of coverage provision.

Your participation in the Section 125 Premium Conversion Plan will terminate effective the first of the month for which no Employee Contribution was withheld from your paycheck.

ADMINISTRATION

The Section 125 Premium Conversion Plan is administered by the University of South Alabama. All costs associated with the administration of this plan are paid for by the University of South Alabama. Additional information may be obtained from the Human Resources Department.
Some words and terms have a specific meaning and are capitalized when used in this Member Handbook. This section will assist you in understanding the specific meaning of those words and terms. Please read this section carefully.

The following are defined within the content of the Member Handbook on the stated page:

- Admission Deductible ……………………………………. 13
- Allowed Amount or Allowance …………………………. 38
- Blue Cross Blue Shield In-Network ……………………….. 12
- BlueCard® Program ……………………………………………….. 12
- Calendar Year Deductible or Deductible ………………. 13
- Calendar Year Out-of-Pocket Maximum ………………. 13
- Change-in-Status Event ………………………………………. 9
- Coinsurance ……………………………………………………… 13
- Copay or Copayment ………………………………………….. 13
- Covered Services ……………………………………………… 25
- Diagnostic Imaging …………………………………………… 29
- Eligible Dependents …………………………………………. 6
- Excess of Allowed Amount or Allowance ………………. 13
- Mental Health & Substance Abuse …………………….. 27
- Open Enrollment Period ……………………………………… 9
- Out-of-Area Services …………………………………………. 13
- Out-of-Network or Non-PPO ………………………………. 13
- Pharmacy Network …………………………………………… 12
- Required Documentation …………………………………… 6
- Special Enrollment Period …………………………………… 9
- USA Health …………………………………………………….. 12

The following definitions will assist with your understanding of the Plan’s provisions:

1. **Accidental Injury:** See “injury.”

2. **Administrator or Claims Administrator:** The corporation appointed by the University of South Alabama to be responsible for the functions and administration of the USA Health & Dental Plan. The Claims Administrator is Blue Cross Blue Shield of Alabama for medical claims and Express Scripts, Inc. for pharmacy benefits.

3. **Application:** The Employee’s or dependent’s written application form requesting coverage under the Plan and authorizing the required Employee Contribution together with any other Required Documentation. Acceptable proof of dependent status is stated in the table of Required Documentation. Acceptance of the Application is evidenced by the issuance of an identification card or by other written notice of acceptance to the Employee.

4. **Bariatric:** Refers to any service, condition or expense to affect weight reduction or treat obesity including bariatric surgery, gastric restrictive procedures and complications arising from bariatric and gastric restrictive procedures.

5. **Benefit Limitations:** The maximum liability for Covered Services incurred by a Member while covered under the Plan, as stated in the schedule of benefits including: quantity limits or number of days covered, number of visits or treatment sessions, or age limits on coverage.

6. **Calendar year or year:** The calendar year or benefit period is from January 1st through December 31st of any given year.

7. **Complications of Pregnancy:** Any condition resulting in Hospital confinement, the diagnosis of which is distinct from pregnancy but is adversely affected or caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar conditions of comparable severity, non-elective cesarean delivery, ectopic pregnancy which is terminated and spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible. False labor, occasional spotting, Physician prescribed rest, morning sickness, hyperemesis gravidarum, preeclampsia and conditions associated with a difficult pregnancy are not Complications of Pregnancy.

8. **Cosmetic:** Any service, expense or surgical procedure that primarily improves or changes appearance and does not primarily improve physical bodily functions or correct deformities resulting from disease, Injury or congenital anomalies. Improvement of physical bodily function does not include improvement of psychological effects caused by physical defects or conditions. The exclusion of Cosmetic treatment does not include Reconstructive Surgery.
9. **Custodial Care:** Care comprised of services and supplies which are provided to assist in the activities of daily living for a Member who is mentally or physically incapacitated.

10. **Dependent Coverage:** Coverage for an Eligible Dependent when the Employee has made Application and payment of the required Employee Contribution.

11. **Disability or Disabled:** A total incapacitation resulting from an Illness or Injury which occurs while the individual is covered under this Plan and results in the complete inability of an Employee to perform any and every duty pertaining to any occupation, or the complete inability of a dependent child to perform the activities of daily living of a person of like age and sex as evidenced by a Social Security Administration disability entitlement.

12. **Durable Medical Equipment:** To be Durable Medical Equipment, an item must at a minimum be: (1) made to withstand repeated use; (2) for a medical purpose rather than for comfort or convenience; (3) useful only if the Member is sick or injured; (4) ordered and prescribed by a Physician for use in the Member’s home; and (5) directly related to the patient’s physical disorder. The Plan will consider the equipment as a Covered Service only when the item in question is the least costly available to provide treatment (for example, a manually operated wheelchair rather than a motorized wheelchair). Durable Medical Equipment must be Precertified by the Claims Administrator and must be provided by a Blue Cross Blue Shield Provider.

13. **Effective Date:** The date the Employee and/or Eligible Dependent becomes covered under the Plan based on the eligibility rules and acceptance and approval of the written Application by the Human Resources Department.

14. **Eligible Employee:** An Employee who has made Application to the Human Resources Department for coverage and authorization for payroll deduction of the Employee Contribution, and has had such Application approved.

15. **Emergency Admission:** An admission to a Hospital, made through the emergency department, when immediate medical care is required as a result of a severe, life threatening or potentially disabling condition (a type 1 emergency as defined in the manual of the Health Care Financing Administration, Centers for Medicare and Medicaid Services).

16. **Employee:** An employee of the University of South Alabama, USA HealthCare Management, LLC or an affiliated employer entity.

17. **Employee Contribution:** The amount required to be paid for coverage under the Plan by an Employee, Surviving Dependent or COBRA participant. Only Members for whom the required contribution, applicable funding rate or COBRA premium is received by the Employer (or Claims Administrator when required) shall be entitled to eligibility under the Plan. All rights of the Member under the Plan shall terminate as of the last day of the month for which the required payment has been properly received.

18. **Employer:** The University of South Alabama, USA HealthCare Management, LLC, or an affiliated employer entity.

19. **Employer Contribution:** The Employer Contribution is that amount paid by the Employer on behalf of the Members. No Member, beneficiary or third party shall have any right, title or interest in the Employer Contribution or any part thereof except as provided in the form of benefits through the USA Health & Dental Plan.

20. **Experimental or Investigative:** Any treatment, procedure, facility, equipment, drugs, drug usage, or supplies either not recognized by the Claims Administrator as having scientifically established medical value or not in accordance with generally accepted standards of medical practice. Covered Services include only technology or treatment which meet all of the following criteria: (1) have final approval from the appropriate governmental regulatory bodies for the specific use for which it is intended; (2) permit conclusions concerning the effect on health outcomes; (3) improve net health; (4) be as beneficial as any established alternatives; (5) be classified and approved by the Claims Administrator. Experimental or Investigative treatment may be covered for an approved clinical trial to treat cancer or other life-threatening diseases as required by the Affordable Care Act.

21. **FDA:** Federal Drug Administration.
22. **Family and Medical Leave Act (FMLA):** The Family and Medical Leave Act of 1993, as amended, which requires that employers who offer group health coverage to their employees continue to make that coverage available while an Eligible Employee is on qualified leave.

23. **Generic Drug:** One that has been approved by the Food and Drug Administration as therapeutically equivalent to the original “name brand” drug. The FDA approves the generic equivalent as interchangeable with the brand-name drug under all approved indications and conditions for use. The lowest Copay applies to generic drugs under the Prescription benefit.

24. **Home Care Medical Supplies:** Medical supplies ordered by a Blue Cross Blue Shield Provider Physician for home use and required due to chronic Illness, limited to only: oxygen, IV therapy solutions, crutches, splints, casts, trusses and braces, specialty dressings for open wounds, syringes and needles, blood glucose strips, lancets and glucose monitors, tubing kits for insulin pumps, catheters, colostomy bags, compression stockings and medical supplies required in conjunction with an authorized Home Health Care visit.

25. **Hospice Care:** Care provided by an agency or organization which: (1) provides hospice care; (2) is licensed or certified; and (3) meets the standards established by the National Hospice Organization. Hospice Care is a coordinated, interdisciplinary program to meet the physical, psychological and social needs of Terminally Ill persons by providing palliative and supportive medical, nursing and other health services. Hospice Care may include short-term inpatient hospital stays required for the Terminally Ill person in order to give temporary relief to a caregiver who regularly assists with home care (limited to five days during any 90 day period).

26. **Hospital:** A facility licensed as a hospital, operated for the care and treatment of resident inpatients, which has a laboratory, registered graduate nurses always on duty and an operating room where major surgical operations are performed. In no event shall the term hospital include an institution or that part of an institution which is used principally as a clinic, convalescent home, rest home, nursing home or home for the aged, drug addicts or alcoholics.

27. **Illness:** A disease, disorder or condition that requires treatment by a Physician, occurring while the Member is covered under the Plan.

28. **Injury or Accidental Injury:** A traumatic injury requiring immediate medical attention, caused solely by accident and occurring while the Member is covered under the Plan.

29. **Medical Emergency:** An Injury or a sudden unexpected onset of an Illness which requires immediate diagnosis or medical or surgical treatment. This condition must require that the Member seek immediate medical attention from the nearest available facility, and which if not performed without delay would jeopardize or impair the Member’s life or health (a type 1 emergency or type 2 urgent care condition as defined in the manual of the Health Care Financing Administration [Centers for Medicare and Medicaid Services]). Use of an emergency room for treatment that is not a Medical Emergency, as determined by the Claims Administrator, will be paid according to the Major Medical benefits schedule, at 80% subject to the Calendar Year Deductible.

30. **Medical Necessity or Medically Necessary:** Benefits are provided only for services and supplies determined by the Claims Administrator to be Medically Necessary.

   To be Medically Necessary the service or supplies must at a minimum be: (1) appropriate and necessary for the symptoms, diagnosis and treatment of the medical condition; (2) provided for the diagnosis or direct care and treatment of the medical condition; (3) in accordance with standards of good medical practice accepted by the organized medical community; (4) not primarily for the convenience and/or comfort of the Member, family, physician, or another provider of services; (5) not experimental or investigative; (6) performed in the least costly setting, method, or manner, or with the least costly supplies required by your medical condition. Evidence to help determine whether the service is Medically Necessary may be required before benefits are provided. The fact that the treating physician finds that the treatment is medically necessary is not binding on the Plan.
31. **Member:** An Eligible Employee or Eligible Dependent based on the established eligibility provisions and payment of the required contribution, for whom Application has been accepted by the Human Resources Department.

32. **Member Handbook:** This written description of the benefit plan in an easy-to-read format, including eligibility, benefits, employee rights and responsibilities, and appeals procedure. The USA Health & Dental Plan Management Committee reserves the right to interpret the Plan, to amend or change the Plan, terminate any or all benefits and to make final determinations with regard to all matters concerning the Plan.

33. **Nursing Care or Private Duty Nursing:** Only intermittent services (less than an eight-hour shift) provided by a registered nurse, licensed practical nurse or home health aide who is not related to the Member nor regularly resides in the Member’s household. The services must be ordered by a Physician and performed outside of a Hospital or any other acute care facility setting by a Blue Cross Blue Shield Provider. No benefits are provided for Custodial Care.

34. **Physician:** Any healthcare provider when licensed and acting within the scope of that license or certification at the time and place the Member is treated or receives services.

35. **Plan:** The USA Health & Dental Plan as described in this Member Handbook.

36. **Precertification:** The administrative procedure whereby the Member or Physician is required to submit information or a treatment plan to the Claims Administrator before the treatment or expense is initiated. The Claims Administrator reviews the treatment plan for approval before those services or expenses are considered eligible for reimbursement under the Plan.

37. **Primary Care Physician:** Includes a Family Practitioner, General Practitioner, Pediatrician, Internist, Gynecologist, Obstetrics-Gynecologist, Obstetrics, Gynecological-Oncologist, Certified Registered Nurse Practitioner, Certified Nurse Midwife, Physician’s Assistant, or Emergent Care Clinic (Specialty code 070).

38. **Pregnancy:** The condition of and complications arising from a woman having a fertilized ovum, embryo or fetus in her body, usually but not always in the uterus, lasting from the time of conception to the time of childbirth, abortion, miscarriage or other termination.

39. **Qualified Medical Child Support Order (QMCSO):** A QMCSO is a judgment, decree or order issued by a court of competent jurisdiction that requires the USA Health & Dental Plan to enroll dependents named in the order.

40. **Reconstructive surgery:** Reconstructive surgery and procedures are Covered Services under the Plan when: (1) determined to be Medically Necessary; (2) intended to primarily improve or restore physical bodily function or correct deformities resulting from Illness, Injury or congenital anomalies; and, (3) do not serve primarily to improve or change appearance. In some circumstances, a surgical procedure may be considered Reconstructive, or a portion of a Cosmetic surgery would be covered as Medically Necessary Reconstructive Surgery. You and your Physician must contact the Claims Administrator prior to treatment for determination of whether a procedure will be treated as Cosmetic or Reconstructive.

41. **Renal Dialysis Facility:** A free-standing facility approved for participation in the Medicare program.

42. **Required Documentation:** Acceptable proof of dependent status is stated in the table of Required Documentation. Proof must be filed within 30 days of enrollment or when requested by the Human Resources Department to be deemed Required Documentation.

43. **Skilled Nursing Facility:** A Medicare-approved facility providing non-acute care for patients requiring 24-hour nursing services to assist patients to reach a degree of body functioning to permit self-care in essential daily living activities. A Skilled Nursing Facility: (1) is engaged in providing skilled care under the supervision of Physicians and registered nurses; (2) maintains clinical records on all patients; (3) provides 24-hour nursing services; and (4) provides appropriate procedures for dispensing and administering drugs and is duly licensed. Facilities for custodial, domiciliary care, Mental Health or Substance Abuse treatment are not covered.

44. **Specialty Care Physician:** One who is not a Primary Care Physician.
45. **Specialty Drug**: Prescription drugs often referred to as biotech drugs or biologics, which include high cost oral, injectable, and infusion drugs that are administered for specific chronic conditions, such as hemophilia, fertility, multiple sclerosis, and rheumatoid arthritis. Express Scripts has a Specialty Pharmacy Network for dispensing Specialty Drugs.

46. **Substance Abuse Treatment**: Treatment for a chronic disorder or Illness in which the Member is unable, for psychological or physical reasons, or both, to refrain from the frequent consumption of alcohol, drugs, intoxicants or narcotics in quantities sufficient to produce intoxication or overdose and, ultimately, injury to health and effective functioning.

47. **Terminally Ill**: A patient who is determined by a Physician to have a terminal Illness with no reasonable prospect of cure and who is expected by a Physician to have less than six months to live.

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### Specific Benefit Exclusions

Some medical treatments, services and prescription drugs require pre-authorization or precertification of Medical Necessity. Failure to obtain an authorization may result in a denial of benefits. Benefits requiring a prior authorization are stated herein and include but are not limited to—

Precertification is required for all Hospital admissions except maternity admissions. Emergency admissions must be Pre-certified within 48 hours of admission. If you are unable to communicate, someone may call for you. If you are unable to communicate and no one is available to call for you, the deadline for Precertification is extended to 48 hours after you regain the ability to communicate. You should check with your admitting Physician to ensure your admission has been Pre-certified. Failure to Pre-certify a Hospital admission may result in a denial of benefits, call 1-800-248-2342.

Certain diagnostic imaging services may require prior authorization as to the Medical Necessity of the diagnostic service. Information about these prior authorization requirements can be found at [www.bcbsal.com/providers/preferredRadiologyProgram](http://www.bcbsal.com/providers/preferredRadiologyProgram).

All Home Health Care services and Extended Care require Precertification. Failure to Pre-certify may result in denial of benefits, call **1-800-821-7231**.

All organ and bone marrow transplants (excluding kidney) must be performed in a hospital or other facility on the list of approved facilities for that type of transplant and it must have advance written approval from the Claims Administrator.

Some prescription drugs and Specialty Drugs require Prior Authorization in order to be covered by the Plan. Prior Authorization can be obtained by contacting **Express Scripts** at **1-855-687-3857**. You may also find out more about this process at [express-scripts.com](http://express-scripts.com).

You and your physician or medical provider ultimately decide on the medical treatment that best manages your medical condition and this may include medical care that is not covered by the Plan.
REVIEW REQUEST

There are a number of reasons why your claim may be denied in whole or in part. You should carefully read any denial received, and review this Member Handbook to ensure that you understand the reason for the denial.

If you are dissatisfied with the handling of a claim or have any questions, you may do one or more of the following: 1) you may contact the Customer Service Department for assistance; 2) you may file a request for review if you have received an adverse benefit determination.

MEDICAL & DENTAL

Medical and dental benefit reviews are performed by Blue Cross Blue Shield and it is recommended that you use the form provided by the Claims Administrator, go to

www.AlabamaBlue.com

Or you may send a letter to

Blue Cross Blue Shield of Alabama
Attention: Customer Service Appeals
P. O. Box 12185
Birmingham, Alabama 35202-2185
1-800-248-2342

PHARMACY

Pharmacy benefit reviews are performed by Express Scripts, Inc. The review request should be sent to

Express Scripts
Attention: Administrative Appeals Dept.
P.O. Box 66587
St. Louis, MO  63166-6587
1-800-946-3979

The request for review must contain at least the following information:

1. the patient’s name and contract number;
2. sufficient information to identify the claim, such as date of service, provider name, and claim number – include a copy of your Claims Report with the request;
3. an explanation of the situation and why you feel the benefit determination is incorrect;
4. any evidence or other information such as a letter from the physician that supports your case.

The Claims Administrator will notify you within 60 days of receipt of your request for review of the determination or explain why additional time or information is required.

ELIGIBILITY & SECONDARY REVIEW

Eligibility is managed by the University’s Human Resources Department and inquiries should be sent direct to that Department. Also, if after you have followed the procedure for review by the Claims Administrator, you are not satisfied, you may request a secondary review:

1. Except for questions concerning eligibility, you must first comply with the review procedure to the Claims Administrator;
2. All communications and records concerning your review must be submitted as part of your request for review by the University;
3. You must request a review within 60 days of the Claims Administrator’s response or the denial of a benefit or coverage.

All information must be submitted in writing to

University of South Alabama HR Dept.
650 Clinic Drive
Technology & Research Park
Building III, Suite 2200
Mobile, AL  36688

Your request for review will be considered by the USA Management Committee and you will receive a written response within 60 days. If you are not satisfied, you may also file a written request for an independent external review within 4 months of the decision with Human Resources.

LIMITATION OF LIABILITY

No action may be brought against the University of South Alabama or the Claims Administrator unless, prior to any action being brought, the Member has fully complied with the terms and provisions of the USA Health & Dental Plan.

Further, no legal action may be commenced against the Plan, the University of South Alabama or the Claims Administrator, individually or collectively, more than one year after the date of the USA Health & Dental Plan Management Committee’s final decision on your request for review.