This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.southalabama.edu/hr or by calling (251) 460-6133

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$400** person. Does not apply to preventive services, physician, inpatient, non-covered services, balance-billed charges and pre-certification penalties.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. **$750** person per admission. **$100** per person pharmacy limited to 3 per family. There are no other specific **deductibles**.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes. **$1850** individual and **$3700** family for network essential services and **$6850** individual and **$13,700** family for network essential services combined medical and pharmacy benefits.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premium, balance-billed charges, health care this plan doesn't cover, drugs, and pre-certification penalties.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes, this plan uses in-network providers. For a list of in-network providers, see AlabamaBlue.com or call 1-800-810-BLUE.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

Questions: Human Resources at (251) 460-6133 or www.southalabama.edu/hr.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call 1-877-345-6171 to request a copy.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use an In Network Provider	Your cost if you use an Out of Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	0% coinsurance & $35 copay	20% coinsurance	$10 copay applies for USA Health network providers; subject to overall deductible for out-of-network; in Alabama, out-of-network covered the same as in-network for medical emergency or accidental injury only
	Specialist visit	0% coinsurance & $35 copay	20% coinsurance	$10 copay applies for USA Health network providers; subject to overall deductible for out-of-network; in Alabama, out-of-network covered the same as in-network for medical emergency or accidental injury only
	Other practitioner office visit	20% coinsurance for chiropractor	20% coinsurance for chiropractor	Subject to overall deductible; in Alabama, out-of-network not covered
	Preventive care/screening/immunization	No Charge	Not Covered	Please see AlabamaBlue.com/preventiveservices; additional services may be available
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	20% coinsurance	Benefits listed are physician services; subject to overall deductible for out-of-network; in Alabama, out-of-network covered the same as in-network for medical emergency or accidental injury only
	Imaging (CT/PET scans, MRIs)	No Charge	20% coinsurance	Benefits listed are physician services; subject to overall deductible for out-of-network; in Alabama, out-of-network covered the same as in-network for medical emergency or accidental injury only; precertification may be required for coverage

Common Medical Event	Services You May Need	Your cost if you use an In Network Provider	Your cost if you use an Out of Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition	Tier 1 – Generic	$10	Not Covered	Subject to the prescription drug out-of-pocket (OOP) limit of $5,000 individual and $10,000 family.
	Tier 2 - Formulary Brand	$50	Not Covered	Subject to the prescription drug out-of-pocket (OOP) limit of $5,000 individual and $10,000 family.
	Tier 3 – Non-Formulary Brand	$75	Not Covered	Subject to the prescription drug out-of-pocket (OOP) limit of $5,000 individual and $10,000 family.
	Tier 4 - Specialty	50% Coinsurance until OOP is met	Not Covered	Subject to the prescription drug out-of-pocket (OOP) limit of $5,000 individual and $10,000 family.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance & $250 copay	Not Covered	No charge for services rendered by USA Health network provider; in Alabama, out-of-network covered the same as in-network for medical emergency or accidental injury only
	Physician/surgeon fees	No Charge	20% coinsurance	No charge for services rendered by USA Health network provider; subject to overall deductible for out-of-network; outside Alabama, out-of-network covered the same as in-network for medical emergency or accidental injury only
If you need immediate medical attention	Emergency room services	No Charge	No Charge	Benefits listed are for emergency room services for treatment of accidental injury; other medical emergencies may have higher patient responsibility; physician charges may apply
	Emergency medical transportation	20% coinsurance	20% coinsurance	Subject to overall deductible
	Urgent care	0% coinsurance & $35 copay	20% coinsurance	$10 copay applies for USA Health network providers; subject to overall deductible for out-of-network; in Alabama, out-of-network covered the same as in-network for medical emergency or accidental injury only
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance & $100 copay days 2-5 & $750 per admission	Not Covered	No charge for services rendered by USA Health network provider; outside Alabama, out-of-network covered the same as in-network for medical emergency or accidental injury only; precertification is required for coverage
	Physician/surgeon fee	No Charge	20% coinsurance	Subject to overall deductible for out-of-network; in Alabama, out-of-network covered the same as in-network for medical emergency or accidental injury only

Common Medical Event	Services You May Need	Your cost if you use an In Network Provider	Your cost if you use an Out of Network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	0% coinsurance & $25 copay	0% coinsurance & $25 copay	$10 copay applies for USA Health network providers; limited to a combined maximum of 60 visits for outpatient mental health and substance abuse per member per calendar year
	Mental/Behavioral health inpatient services	20% coinsurance	20% coinsurance	Subject to overall deductible; out-of-network covered for medical emergencies or accidental injury only; limited to 30 inpatient days per person per calendar year and a lifetime maximum of 60 inpatient days per member; precertification is required for coverage
	Substance use disorder outpatient services	20% coinsurance	20% coinsurance	Subject to overall deductible; limited to a combined maximum of 60 visits for outpatient mental health and substance abuse per member per calendar year
	Substance use disorder inpatient services	20% coinsurance	20% coinsurance	Subject to overall deductible; out-of-network covered for medical emergencies or accidental injury only; limited to 30 inpatient days per person per calendar year and a lifetime maximum of 60 inpatient days per member; precertification is required for coverage
If you are pregnant	Prenatal and postnatal care	No Charge	20% coinsurance	Benefits listed are for outpatient physician services; subject to overall deductible for out-of-network; in Alabama, out-of-network covered the same as in-network for medical emergency or accidental injury only
	Delivery and all inpatient services	No Charge	20% coinsurance	Benefits listed are for inpatient physician services; subject to overall deductible for out-of-network; in Alabama, out-of-network covered the same as in-network for medical emergency or accidental injury only

Common Medical Event	Services You May Need	Your cost if you use an In Network Provider	Your cost if you use an Out of Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	In Alabama, out-of-network not covered; precertification may be required for coverage
	Rehabilitation services	20% coinsurance	20% coinsurance	USA Health network providers are covered at 100% subject to $10 copay per visit; non USA providers subject to overall deductible; limited to a maximum of 60 visits each for occupational, physical and speech therapy per member per calendar year
	Habilitation services	20% coinsurance	20% coinsurance	USA Health network providers are covered at 100% subject to $10 copay per visits; non USA providers subject to overall deductible; limited to a maximum of 60 visits each for occupational, physical and speech therapy per member per calendar year
	Skilled nursing care	No Charge	No Charge	Limited to a maximum of 60 days per member per calendar year; additional limitations apply; precertification is required for coverage
	Durable medical equipment	No Charge	Not Covered	Limited to a maximum of two pair every 12 consecutive months for orthotic devices
	Hospice service	No Charge	Not Covered	Limited to a lifetime maximum of 180 days per member; in Alabama, out-of-network not covered; precertification may be required for coverage
If your child needs dental or eye care	Eye exam	No Charge	Not Covered	Benefits listed are mandated preventive services; please see AlabamaBlue.com/preventiveservices; additional benefits are available; limitations apply
	Glasses	Not Covered	Not Covered	Not covered; member pays 100%
	Dental check-up	No Charge	Not Covered	Benefits listed are mandated preventive services; please see AlabamaBlue.com/preventiveservices; additional benefits are available; limitations apply

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)		
• Acupuncture	• Hearing aids	• Private-duty nursing
• Cosmetic surgery	• Long-term care	• Routine foot care
• Glasses, child	• Prescription Drugs	• Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
• Bariatric surgery (Only morbid obesity in limited circumstances)	• Dental care (Adult) (Limitations apply)	• Non-emergency care when traveling outside the U.S.
• Chiropractic care	• Infertility treatment (Assisted Reproductive Technology not covered)	• Routine eye care (Adult) (Limitations apply)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan administrator at the phone number listed in your benefit booklet. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact the Human Resources Department at (251) 460-6133. You may also contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have healthcare coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% health coverage.

This Plan does meet the minimum value standard for the benefits it provides.

Language Access Services:

SPANISH (Español): Para obtener asistencia en Español, llame al 1-877-345-6171.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,480
- **Patient pays** $1,060

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$890
Coinsurance	$0
Limits or exclusions	$170
Total	**$1,060**

Note: These numbers assume the patient has given notice of her pregnancy to the plan. If you are pregnant and have not given notice of your pregnancy, your costs may be higher. For more information, please contact: AlabamaBlue.com

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $880
- **Patient pays** $4,520

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$20
Copays	$210
Coinsurance	$0
Limits or exclusions	$4290
Total	**$4,520**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: AlabamaBlue.com

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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

Language Access Services and Notice of Nondiscrimination:

Blue Cross and Blue Shield of Alabama complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. We do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Blue Cross and Blue Shield of Alabama:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages

If you need these services, contact our 1557 Compliance Coordinator. If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person or by mail, fax, or email at: Blue Cross and Blue Shield of Alabama, Compliance Office, 450 Riverchase Parkway East, Birmingham, Alabama 35244, Attn: 1557 Compliance Coordinator, 1-855-216-3144, 711 (TTY), 1-205-220-2984 (fax), 1557Grievance@bcbsal.org (email). If you need help filing a grievance, our 1557 Compliance Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Service, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Foreign Language Assistance

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-216-3144 (TTY: 711)

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-216-3144 (TTY: 711)번으로 전화해 주십시오.

Chinese: **注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電** 1-855-216-3144 (TTY: 711）。

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-216-3144 (TTY: 711).

Arabic: 711: .)الهاتف النصي(3144-216-855-1)اتصل بـ .انتباه :إذا كنت تتحدث العربية، توجد خدمات مساعدة فيما يتعلق باللغة، بدون تكلفة، متاحة لك

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-216-3144 (TTY: 711).

French: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-216-3144 (ATS: 711).

French Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-855-216-3144 (TTY: 711).

Gujarati: □□□□□ □□□: □□ □□□ □□ □□ □□□ □□□, □□ □□ □□ □, □□□ □□ □□ □□ □□□□ □□□□ □ □□□□□□ □□. 1-855-216-3144 □□□ □□□ □□ (TTY: 711).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-216-3144 (TTY: 711).

Hindi: □□□□□ □□□: □□□ □□□□ □ □□, □□ □□□ □□□ □□ □□ □□□ □□□□ □□□□ □□ □□□□ □□□□□□ □□□□ 1-855-□□□□ □ □□ 216-3144 (TTY: 711) □□ □□□ □□□□ □

Laotian: □□□□□□: □ □□ □ □ □□□ □ □□□□□ □□□, □□ □□□□□□, □□□□□ □□□ □□ □, □□ □□ □ □□□□ □ □□. □□□□ □□ □□□□□ □ □□□□□□ (TTY: 711).

□□□ 1-855-216-3144

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-216-3144 (телетайп: 711).

Portuguese: ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-855-216-3144 (TTY: 711).

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-855-216-3144 (TTY: 711).

Turkish: DİKKAT: Eğer Türkçe konuşuyor iseniz, dil yardımı hizmetlerinden ücretsiz olarak yararlanabilirsiniz. 1-855-216-3144 (TTY: 711) irtibat numaralarını arayın.

Italian: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-216-3144 (TTY: 711).**Japanese:** 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-855-216-3144（TTY: 711）まで、お電話にてご 連絡ください。