BlueCross BlueShield of Alabama

USA Health & Dental Plan - Select Plan #67307

Coverage Period: 01/01/2022 – 12/31/2022

Coverage For: Individual + Family **Plan Type:** PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call **(251) 460-6133** or visit us at **www.southalabama.edu/hr.** For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.bcbsal.org/sbcglossary/ or call 1-800-292-8868 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes. Preventive services in-network are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. $100 individual/$300 family maximum prescription drug deductible. 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.
What is the out–of–pocket limit for this plan?	For in-network $8,000 individual/$16,000 family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limit until the overall family out-of-pocket limit has been met.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, health care this plan doesn't cover, pre-certification penalties and specialty drug coupon program payments.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See AlabamaBlue.com or call 1-800-810-BLUE for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out of Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No Charge No overall deductible	Not Covered	Benefits listed are USA Health Network providers; other in-network PPO providers subject to 30% coinsurance; out-of-network covered for medical emergency or accidental injury only
	Specialist visit	No Charge No overall deductible	Not Covered	
	Preventive care/screening/ immunization	No Charge No overall deductible	Not Covered	Please visit AlabamaBlue.com/preventiveservices; additional services are available. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge No overall deductible	Not Covered	Benefits listed are USA Health Network; other in-network PPO providers subject to 30% coinsurance; benefits listed are physician benefits; facility benefits are also available; precertification may be required; out-of-network covered for medical emergency or accidental injury only
	Imaging (CT/PET scans, MRIs)	No Charge No overall deductible	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out of Network Provider (You will pay the most)	
More information about **prescription drug coverage** is available at AlabamaBlue.com/pharmacy	Tier 1 Drugs (preferred generic)	$10 copay (retail) $10 copay (mail order) No overall deductible	Not Covered	Prior authorization required for specific drugs; subject to a separate $100 individual/$300 family prescription drug deductible; mail order and extended supply network available for a 90 day supply subject to two copays; drugs in Specialty Drug Coupon Program, subject to greater of applicable Tier copay or the available payment under the specialty drug coupon program; go to Alabamablue.com/specialtycouponprogramdruglist for a list of these specialty drugs.
	Tier 2 Drugs (non-preferred generic)	$10 copay (retail) $10 copay (mail order) No overall deductible	Not Covered	
	Tier 3 Drugs (preferred brand)	$50 copay (retail) $50 copay (mail order) No overall deductible	Not Covered	
	Tier 4 Drugs (non-preferred brand)	$75 copay (retail) $75 copay (mail order) No overall deductible	Not Covered	
	Tier 5 Drugs (preferred specialty)	$150 copay (retail) No overall deductible	Not Covered	
	Tier 6 Drugs (non-preferred specialty)	50% coinsurance No overall deductible	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge No overall deductible	Not Covered	Benefits listed are USA Health network provider; other in-network facilities subject to 30% coinsurance; out-of-network covered for medical emergency or accidental injury only
	Physician/surgeon fees	No Charge No overall deductible	Not Covered	Benefits listed are USA Health Network; other PPO providers subject to 30% coinsurance; out-of-network covered for medical emergency or accidental injury only
If you need immediate medical attention	Emergency room care	Accident: No Charge No overall deductible Medical Emergency: No Charge No overall deductible	Accident: No Charge No overall deductible Medical Emergency: No Charge No overall deductible	Physician charges will apply; in-network benefits listed are USA Health Network facility and PPO facilities; includes mental health disorders and substance abuse emergency services.
	Emergency medical transportation	30% coinsurance	30% coinsurance	Services required to be medically necessary.
	Urgent care	No Charge No overall deductible	Not Covered	Benefits listed are USA Health Network; other in-network PPO providers subject to 30% coinsurance; out-of-network covered for medical emergency or accidental injury only

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out of Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge No overall deductible	Not Covered	Benefits listed are for USA Health Network facilities; other in-network PPO facilities subject to 30% coinsurance; out-of-network covered for medical emergency or accidental injury only; precertification is required for coverage
	Physician/surgeon fees	No Charge No overall deductible	Not Covered	Benefits listed are for USA Health Network; other PPO providers subject to 30% coinsurance; out-of-network covered for medical emergency or accidental injury only
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No Charge No overall deductible	Not Covered	Benefits listed are for USA Health Network providers; other in-network outpatient PPO Providers subject to 30% coinsurance; outpatient substance abuse services limited to a combined maximum of 60 days for outpatient mental health and substance abuse per member per calendar year; inpatient facility and physician limited to a maximum of 60 days per lifetime; out-of-network coverage available only for medical emergencies and accidental injury
	Inpatient services	No Charge No overall deductible	Not Covered	
If you are pregnant	Office visits	No Charge No overall deductible	Not Covered	Benefits listed are for USA Health Network providers; other in-network outpatient PPO Providers subject to 30% coinsurance; cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound); out-of-network coverage only available for medical emergencies and accidental injury
	Childbirth/delivery professional services	No Charge No overall deductible	Not Covered	
	Childbirth/delivery facility services	No Charge No overall deductible	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out of Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	No Charge No overall deductible	Not Covered	Precertification is required for coverage; limited to 60 visits per member per calendar year; benefits are also available for home infusion services
	Rehabilitation services	No Charge No overall deductible	Not Covered	Benefits listed are for Habilitation and Rehabilitation; each service limited to 60 visits per therapy per person per calendar year; benefits listed are for USA Health Network; other in-network PPO providers, subject to 30% coinsurance
	Habilitation services	No Charge No overall deductible	Not Covered	
	Skilled nursing care	30% coinsurance	30% coinsurance	Limited to a maximum of 60 days per member per calendar year; precertification is required
	Durable medical equipment	No Charge No overall deductible	Not Covered	Benefits listed are for USA Health Networks and other PPO providers; includes benefits for orthotic devices; limited to a maximum of two pair each 12 consecutive months
	Hospice services	No Charge No overall deductible	Not Covered	Limited to a lifetime maximum of 180 days per member; precertification may be required for coverage
If your child needs dental or eye care	Children's eye exam	No Charge No overall deductible	Not Covered	Benefits listed are mandated preventive services; please visit AlabamaBlue.com/preventiveservices; additional benefits are available; limitations apply
	Children's glasses	Not Covered	Not Covered	Not covered; member pays 100%
	Children's dental check-up	No Charge No overall deductible	Not Covered	

USA Health is a network of hospitals, physicians, clinics, and other medical providers associated with the University of South Alabama. USA Health offers the highest level of benefits offered. The USA Select Plan also includes all Blue Cross Blue Shield providers at a lesser benefit. Except for medical emergency there are no benefits for out-of-network providers.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Acupuncture	• Hearing aids	• Routine foot care
• Cosmetic surgery	• Long-term care	• Prescription Drugs
• Dental care (Adult)	• Glasses, child	• Private-duty nursing

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric surgery (Only morbid obesity in limited circumstances)	• Infertility treatment (Assisted Reproductive Technology not covered)	• Routine eye care (Adult) (limitations apply)
• Chiropractic care (limited to 60 visits per member per calendar year)	• Non-emergency care when traveling outside the U.S.	• Eye exam, child (limitations apply) • Weight Loss Programs

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Your plan administrator at the phone number listed in your benefit booklet. You may also contact Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

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

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

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in network pre natal care and a hospital delivery)

- The plan's overall deductible $0
- Specialist copay/coinsurance $0/0%
- Hospital (facility) copay/coinsurance $0/0%
- Other copay/coinsurance $35/0%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles*	$0
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$70

Managing Joe's type 2 Diabetes
(a year of routine in network care of a well controlled condition)

- The plan's overall deductible $0
- Specialist copay/coinsurance $0/0%
- Hospital (facility) copay/coinsurance $0/0%
- Other copay/coinsurance $35/0%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$0
Copayments	$460
Coinsurance	$0
What isn't covered	
Limits or exclusions	$40
The total Joe would pay is	$500

Mia's Simple Fracture
(in network emergency room visit and follow up care)

- The plan's overall deductible $0
- Specialist copay/coinsurance $0/0%
- Hospital (facility) copay/coinsurance $0/0%
- Other copay/coinsurance $35/0%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic tests *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$0
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$10

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

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