UNIVERSITY OF SOUTH ALABAMA

EMPLOYEE BENEFITS

University of South Alabama

2025

Here's where to find...

INTRODUCING YOUR EMPLOYEE BENEFITS:

The University of South Alabama appreciates your commitment to our success. We're equally committed to providing you with competitive, affordable health and wellness benefits to help you take care of yourself and your family.

Please read this guide carefully. It has a summary of your plan options and helpful tips for getting the most value from your benefit plans. We understand that you may have questions about your benefits, and we'll do our best to help you understand your options and guide you through the process.

This guide is not your only resource, of course. Any time you have questions about benefits or the enrollment process, you can contact your Human Resources representative by emailing employeebenefitshr@southalabama.edu. Although this guide contains an overview of benefits, for complete information about the plans available to you, please see the summary plan descriptions (SPD's) at www.southalabama.edu/hr

2025 ENROLLMENT ANNOUNCEMENT

The University of South Alabama is proud to offer you a benefit package with a wide range of options for you to choose from. Our goal is to provide competitive and flexible benefits that suit your needs.

You and your dependents can access benefits if you are a regular, benefits-eligible employee working a minimum of 20 hours per week!

Online Benefits Enrollment Portal

We are happy to inform you that Employee Navigator will be used again this year as our benefit enrollment portal. This will allow you to make your benefit elections online. See page 4 for more information!

Medical Benefit Changes
There will be an increase to your 2025 medical premiums. Single coverage premiums will increase $3 per month and family premiums will increase $9 per month for both the USA Choice and USA Select Plans. We are also adding an additional health plan, the USA Consumer High Deductible Health Plan (HDHP), to our benefit offerings.

The USA Choice Plan will have a reduction in the emergency room copay. The copay for Blue Cross Blue Shield Network facilities will decrease to $200. The copay for USA Health Network facilities will remain the same making no differentiation between networks for emergency room visits.

The USA Consumer HDHP will have a $2,000 deductible for single coverage and a $4,000 deductible for family coverage. The plan will provide 80% coinsurance coverage for all USA Health Network providers and 75% for all other BCBS providers. If you enroll in the USA Consumer HDHP, you will be able to contribute to a Health Savings account. USA will contribute $200 for single coverage and $400 for family coverage to your HSA if you decide to enroll in the USA Consumer HDHP and enroll in the HSA with coverage beginning January 1, 2025. The HSA is used to cover out-of-pocket expenses that you may incur during the plan year.

Basic Life and AD&D Insurance
Effective October 1, 2024, The Standard will be the University's Group Life and Disability carrier. Benefits-eligible employees with an annual salary less than $40,000 will now have a flat University paid Basic Term Life and AD&D benefit of $50,000 with no cost to you. There will be no change to the benefit amount if you make over $40,000.

Additional Voluntary Life Insurance Special Enrollment Period
You may enroll in additional voluntary life insurance up to the 1X guaranteed issue amount within your first 30 days of employment without answering medical underwriting questions. If you elect voluntary life coverage for yourself, you may also enroll in spouse and dependent life during this enrollment period without answering medical underwriting questions. After this special enrollment period as a new employee, medical underwriting will be required to increase your life insurance amount.

Eligible Dependents
Please ensure that your coverage only includes those dependents who are eligible for benefits. Eligible dependents include:

- **Spouse** – As recognized by the state of Alabama.
- **Dependent child** – your natural-born child under the age of 26; your stepchild under the age of 26; your legally adopted child, including a legally adopted child living with you as the adopting parent, during a period of probation; a child under age 26 whom you have legal guardian status by court appointment; a child under age 26 for whom you are legally required to provide health insurance coverage pursuant to a Qualified Medical Child Support Order (QMCSO); your disabled child of any age provided the disability commenced prior to age 19.

BENEFITS ENROLLMENT PORTAL

How to Enroll in Benefits

If you are a benefits-eligible employee, you can complete enrollment via our enrollment system, Employee Navigator. There are two ways to register and get started. You may use the email sent with your registration link or by following the steps below.

1. Go to the registration site: https://www.employeenavigator.com/benefits/Account/Register
2. Complete the New User Registration information. Your information **MUST MATCH** what is in Employee Navigator. Your date of birth should be entered as MM/DD/YYYY. You will also enter the last 4 digits of your social security number. If you have trouble registering, reach out to HR for assistance.
3. The Company ID is **USAJAGS**
4. Follow the on screen instructions to create a unique Username and Password.
5. You must agree to the "Terms of Use" to register
6. **You're in! Don't forget your Username and Password!**
7. To log-in again, just return to: https://www.employeenavigator.com/benefits/Account/Login

HOW TO ENROLL IN YOUR BENEFITS

After you have registered as a new user you will then elect your benefits. The steps below will walk you through how to enroll in benefits.

You will need to verify information for your dependents and beneficiaries. **Make sure you have the date of birth and social security numbers for eligible family members you are enrolling in benefits.**

1

Go to www.EmployeeNavigator.com and click Login.

- Returning users: Log in with the username and password you selected previously. Click Reset a forgotten password if needed.
- First time users: Click on your Registration Link in the email sent to you by your admin or Register as a new user. Create an account, and create your own username and password. See steps on page 4 for more information on how to register.

Keep an eye on your inbox for the registration link!

If you are using the email with your registration link, you will not need the company ID listed on page 4.

2

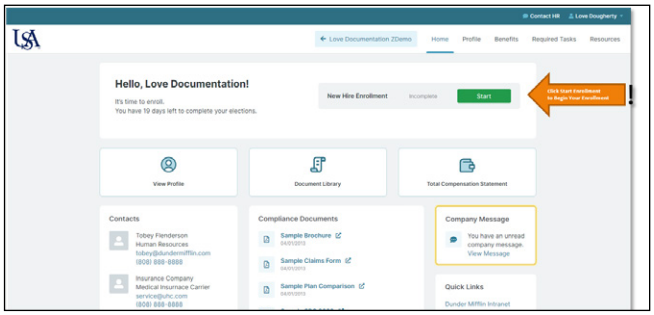
Once logged in you will see a greeting, "Welcome to Your Benefit Enrollment Portal!" Click the green "Continue" button. On the next, screen click "Let's Begin" to get started!

If you need to leave and return later to finish your enrollment elections your work will be saved.

3

You will now be on the home page. This is the starting point for enrolling.

You will be guided through each step of the enrollment process.



4

Next, you will review the personal information for you and your dependents. Make sure addresses, date of births and social security numbers are correct. If any of your personal information is missing or not correct, updates will need to be made through PAWS or you may contact Human Resources.

To add a dependent, click on the green "Add Dependent" button.

If you do not add dependents on the Dependent Information page you will be able to add them on the appropriate Coverage Page(s)!

Necessary documentation must be uploaded in Employee Navigator during the enrollment process to add a dependent to coverage.

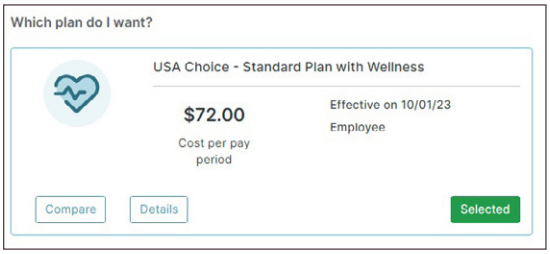
All dependents added to coverage must meet the dependent verification requirements with applicable documentation as listed on page 8 to be eligible for coverage.

5

After you review your personal information on the next screen, you will elect your medical benefits.

Under "Who am I enrolling", you will select the dependents you wish to enroll in medical coverage. Be sure you only enroll dependents who are eligible for coverage.

You will be able to select if you wish to enroll in the USA Choice Plan, USA Select Plan or the USA Consumer Plan (HDHP).

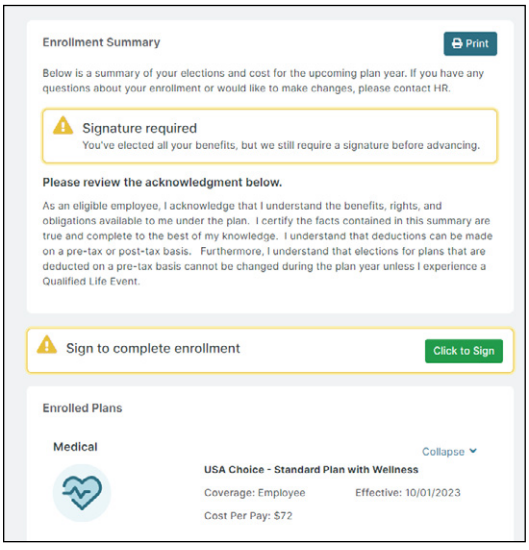


6

After making your election, you will advance to the next page. Repeat the actions in step 5 to enroll in the different coverage options available until you have made a benefit election for each option.

7

IMPORTANT: Review the benefits you selected on the enrollment summary page to make sure they are correct. Then, **Sign & Agree to complete your enrollment**. You can either print a summary of your elections for your records or login at any point during the year to view your summary online.



If you miss a step you'll see the "Enrollment Not Complete" in the progress bar with the Incomplete steps highlighted. Click on any Incomplete steps to complete them!

You must Click to Sign to complete your enrollment!

WHO IS ELIGIBLE?

Benefits are available to you and your dependents if you are a regular, benefits-eligible employee working a minimum of 20 hours per week.

Eligible dependents include:

Your legal spouse

Your children from birth to age 26

(Including your natural/legally adopted children; a legally adopted child living with you as the adopting parent during a period of probation; stepchildren, and/or child who permanently resides in your home and over whom you have legal guardian status by court appointment; your unmarried dependent children of any age who are mentally or physically disabled and who are dependent on you for support.)

MAKING CHANGES

You may only make changes to your benefit elections during open enrollment each year; or during the year if you experience a qualifying life event. Qualifying life events include, but are not limited to:

- Birth, legal adoption, or placement for adoption.
- Marital status.
- Dependent child reaches age 26.
- Spouse gains or loses employment or eligibility with current employer.
- Death of a covered dependent.
- Spouse or dependent becomes eligible or ineligible for Medicare/Medicaid or SCHIP.
- Change in residence that changes eligibility for coverage.
- Court-ordered change.

Changes to your coverage due to a qualifying life event must be made within 30 days of the life event. Proof of the qualifying life event is required (marriage certificate, divorce decree, birth certificate, or loss of coverage letter).

Note: Any change you make to your coverage must be consistent with the change in status.

ENROLLMENT DEADLINES

Type of Event	Enrollment opportunity	Coverage effective date
New hire	Must enroll within 30 days of hire	1st of the following month
Qualified life event	Changes must be made within 30 days of life event	Date of life event

DEPENDENT VERIFICATION

We make every effort to keep benefits affordable for you and your family. One of the ways we can control health care costs is to review the dependents who are enrolled to make sure they are eligible for coverage. If you enroll dependent(s) in the medical plan, you will be asked to verify that your dependent(s) are eligible for coverage. Documentation must be submitted within 30 days of enrollment and when requested by the Human Resources Department.

Required Documentation for Dependent Coverage

Dependent Type	Required Documents
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 you and your spouse • Current property tax documents listing both you and your spouse • Vehicle registration currently in effect listing both you and your spouse • Current credit card or bank account statement listing both you and your spouse • Current utility bill listing you and your 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 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 your spouse • One of the documents listed in the spouse category above as proof of marriage dated prior to 1/1/2017.
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 you and your spouse • Birth certificate issued by state, county or vital records office showing spouse as parent Note: If spouse is not covered by the one of the USA medical plans, 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 or document from an authorized placement agency or by judgment, decree, or other order of any competent jurisdiction for 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 your dependent since the disability commenced
Grandchild	A grandchild may only be covered if legally adopted and living in your home

MEDICAL

www.bcbsal.org

877-345-6171

You have the choice of three medical plans administered through Blue Cross Blue Shield of Alabama – the USA Choice Plan, the USA Select Plan, and the USA Consumer Plan (HDHP). Each medical plan option covers the same services and offer the same pharmacy and dental benefits. All plans have a higher level of benefits when you see a USA Health Network provider.

When you enroll in the USA Select Plan and see a provider that is not part of the USA Health network, you will have coinsurance for most services. The chart below provides a side by side comparison of all plans, including how much each plan pays for various services. If you enroll in the USA Consumer Plan (HDHP), you will have a higher coinsurance if you utilize a provider that is not a part of the USA Health Network.

New Benefit Offering: High Deductible Health Plan, Available 2025!

Medical	USA Choice Plan		USA Select Plan		USA Consumer Plan (HDHP)	
	USA Health Network	BCBS In-network	USA Health Network	BCBS In-network	USA Health Network	BCBS In-network
Annual deductible (Individual/Family)	$125/$250		$125/$250		$2,000/$4,000	
Out-of-pocket maximum (Individual/Family)	$2,250 / $4,500		$ 8,000 / $16,000		$4,000/$8,000	
Preventive care	Covered at 100%		Covered at 100%		Covered at 100%	
Primary physician office visit includes telehealth visits	*Covered at 100% after $15 Copay	*Covered at 100% after $40 Copay	*Covered at 100% after $15 Copay	*70% Coinsurance	*Covered at 80%	*Covered at 75%
Specialist office visit	*Covered at 100% after $15 Copay	*Covered at 100% after $40 Copay	*Covered at 100% after $15 Copay	*70% Coinsurance	*Covered at 80%	*Covered at 75%
Teladoc	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%	*Covered at 75%	*Covered at 75%
Inpatient hospital services	*Covered at 100%	Covered at 100% after $1,000 per admission deductible and $100 Copay for days 2 -5	*Covered at 100%	*70% Coinsurance	*Covered at 80%	*Covered at 75%
Outpatient Surgery	*Covered at 100% after $150 Copay	*Covered at 100% after $350 Copay	*Covered at 100% after $150 Copay	*70% Coinsurance	*Covered at 80%	*Covered at 75%
Diagnostic Services	*Covered at 100%	*Covered at 100% after $50 Copay	*Covered at 100%	*70% Coinsurance	*Covered at 80%	*Covered at 75%
Urgent care	*Covered at 100% after $50 Copay	*Covered at 100% after $50 Copay	*Covered at 100% after $50 Copay	*70% Coinsurance	*Covered at 80%	*Covered at 75%
Emergency room care	*Covered at 100% after $200 Copay - waived if admitted	*Covered at 100% after $200 Copay waived if admitted	*Covered at 100% after $200 Copay waived if admitted	*70% Coinsurance	*Covered at 80%	*Covered at 80%
Prescription drugs						
Annual deductible (Individual/Family) ($300 family maximum)	$100 / $300		$100 / $300		Prescription drugs subject to the annual deductible of $2,000/$4,000	
Retail (30-day supply)						
Tier 1 (Preferred Generic)	$10 Copay		$10 Copay		*Covered at 80%	
Tier 2 (Non-Preferred Generic)	$10 Copay		$10 Copay		*Covered at 80%	
Tier 3 (Preferred Brand)	$50 Copay		$50 Copay		*Covered at 80%	
Tier 4 (Non-Preferred Brand)	$75 Copay		$75 Copay		*Covered at 80%	
Tier 5 (Preferred Specialty Brand)	$150 Copay		$150 Copay		*Covered at 80%	
Tier 6 (Non-Preferred Specialty Brand)	50% Coinsurance		50% Coinsurance		*50% Coinsurance	
Mail order (90-day supply)						
Tier 1 (Preferred Generic)	$20 Copay		$20 Copay		*Covered at 80%	
Tier 2 (Non-Preferred Generic)	$20 Copay		$20 Copay		*Covered at 80%	
Tier 3 (Preferred Brand)	$100 Copay		$100 Copay		*Covered at 80%	
Tier 4 (Non-Preferred Brand)	$150 Copay		$150 Copay		*Covered at 80%	

This is a summary of coverage; please refer to your summary plan description for the full scope of coverage.
*Subject to the calendar year deductible.

IMPORTANT THINGS TO KNOW BEFORE ENROLLING IN THE USA SELECT PLAN OR USA CONSUMER PLAN (HDHP)

The USA Select Plan is a narrow network. Providers that are affiliated with the University of South Alabama make up the USA Health network. This means when you use a USA Health network provider your out-of-pocket cost will be lower. Most services are covered at 100% after a low copay.

The USA Select Plan also offers benefits for providers in the BCBS PPO network. When you use a provider that is part of the BCBS PPO network your out-of-pocket cost will be higher. Benefits are generally covered at 80% in the USA Health network and 70% in the BCBS PPO network leaving you with additional cost.

The USA Consumer Plan (HDHP) offers benefits for providers in the BCBS PPO network and in the USA Health network. When you use a provider that is part of the BCBS PPO network your out-of-pocket cost will be higher. Benefits are covered at 75% leaving you with additional cost once the deductible is met.

Is the USA Select Plan right for me and my family?

- You will pay less in medical premiums if you enroll in the USA Select Plan. The USA Select Plan will save you $648 if you enroll in single coverage, and $2,148 if you enroll in the family plan annually when compared to the USA Choice Plan.
- You and your covered dependents should live in the state of Alabama if you are enrolling in the USA Select Plan.
- To receive the full level of benefits offered under the USA Select Plan, you may need to change **providers if your doctor is not part of the USA Health network. You need to confirm if you and your dependent's doctors are part of the USA Health network before enrolling in coverage.**
- If you see a provider that is not part of the USA Health network or BCBS PPO network, this is considered an out-of-network provider and no benefits are provided. **This means you will be responsible for 100% of the cost.**
- If you enroll in the USA Select Plan and later in the year are not satisfied with your enrollment choice, you will not be able to change your medical election until the next open enrollment.
- If you join the USA Select Plan, and later elect to change plans to the USA Choice Plan, you will be subject to the USA Choice Plan (Standard Premium), even if you were previously enrolled in the USA Choice Plan (Base Premium).

Is the USA Consumer Plan (HDHP) right for me and my family?

- You will pay less in medical premiums if you enroll in the USA Consumer Plan (HDHP), but you will have higher out of pocket costs when you use your benefits.
- You must be prepared to meet the deductible of $2,000 for single coverage or $4,000 for family coverage before the USA Consumer Plan (HDHP) begins to pay.
- You must also meet the annual deductible on the USA Consumer Plan (HDHP) before your pharmacy benefits are covered by insurance.
- If you enroll in the USA Consumer Plan (HDHP), and later in the year you are not satisfied with your enrollment choice, you will not be able to change your medical election until the next open enrollment.

Medical Plan Comparison Tool

- We encourage you to visit the medical plan comparison tool before you enroll in a medical plan to be sure you are enrolling in the plan that's best for you! Visit https://www.comparemyhsa.com/southalabama
- You will be asked a few questions about your and your family's medical and pharmacy usage, as well as any known upcoming medical procedures in the future. Based on your answers, the comparison tool can recommend the best plan for you and your family!

TELADOC

teladoc.com/alabama

855-477-4549

This benefit is only available if you are enrolled in one of the BCBS medical plans. Teladoc gives you access 24 hours, 7 days a week to U.S. board-certified doctors through the convenience of phone, video or mobile app visits. Use Teladoc when you need immediate care, you're considering the ER or urgent care for a non-emergency issue, or traveling out of town. Teladoc can treat many illnesses such as cold & flu symptoms, respiratory infections, sinus problems and many more!

Set up your account today so when you need care, a Teladoc doctor is just a call or click away.

	ONLINE	MOBILE APP	CALL TELADOC
Step 1 **SET UP YOUR ACCOUNT** Set up your account by phone, web or mobile app	Go to teladoc.com/alabama and click "set up account".	Download the app and click "Activate account". Visit teladoc.com/mobile to download the app.	Teladoc can help you register your account over the phone at 855-477-4549.

Step 2 **PROVIDE MEDICAL HISTORY**	Your medical history provides Teladoc doctors with the information they need to make an accurate diagnosis.

Step 3 **REQUEST A CONSULT**	Once your account is set up, request a consult anytime you need care and talk to a doctor by phone, web or mobile app.

VIRTA

REVERSE YOUR PREDIABETES AND TYPE 2 DIABETES

Enroll anytime of year for $0 monthly!

If you or a loved one struggle with type 2 diabetes or high blood sugar, it may be time to explore nutrition therapy with Virta Health.

A virtual nutrition clinic made for real life

Virta is your guided nutrition program to lower blood sugar, reverse diabetes*, and get off unwanted medications—available at $0 cost to you. Personalized and flexible to your lifestyle, learn to eat foods that are right for you. No injections, fad diets, or extra gym visits necessary.

What does the Virta treatment include?

- Free diabetes testing supplies like meters and strips, delivered right to your door
- Doctor-driven support
- Smartphone app for tracking ketones, glucose and weight
- On-demand resources like recipes, grocery lists, meal plans and more

Visit www.virtahealth.com/join/USA or scan the QR code to claim your benefit today.

After you apply, you'll be connected with an enrollment advisor who can answer any questions and help you start your journey towards better health!

10-week member results

18lbs average weight loss	
1.0 average A1C reduction	
94% stopped/ reduced insulin	

The Virta difference

Nutrition, not calorie restriction	Eat until you feel full
Personalized, not one-size-fits-all	Your plan covers your needs & tastes
About the journey, not the judgement	Get caring providers and coaches

To learn more scan the QR code!

PACK HEALTH

www.packhealth.com/usa

855-255-2362

Pack Health provides personalized, one-on-one health coaching, support, education and tools. When you sign up for Pack Health, you are paired with your own personal Health Advisor. A Health Advisor is your personal resource to help you set, track and achieve your health goals.

Have you ever been to the doctor and felt like you didn't get enough time to discuss all of the things you wanted? Or maybe you felt like you received a laundry list of to-dos, but not any direction on how to make those things happen? That's where your Health Advisor comes in!

Health Advisors are non-clinical health professionals – meaning they are not nurses or physicians, but instead, they come from an allied health background such as dietetics, social work, public health and exercise physiology. On top of their various health specializations, they are specifically trained to listen to your story, needs and preferences in order to create personalized plans for your specific goals.

You'll work with your Health Advisor from the comfort of your own home on your schedule. Your Health Advisor reaches out to you on a weekly basis via phone calls, text messages, emails and online lessons. Don't text? No problem. You can choose which communication methods you'd prefer to use.

If you have one of the following conditions, you are eligible to sign up for health coaching:

- Type 2 Diabetes
- Diabetes Prevention
- High Blood Pressure
- Weight Management
- Musculoskeletal Pain
- Cancer
- Hyperlipidemia
- Hip Pain Management
- Knee Pain Management
- Joint Pain Management
- Chronic Pain
- Depression/Behavioral Health
- Migraines
- Congestive Heart Failure
- Rheumatoid Arthritis
- Irritable Bowel Syndrome/ Irritable Bowel Disease
- Crohn's/Colitis
- Multiple Sclerosis
- Psoriasis
- Chronic Kidney Disease
- Nutrition
- Cancer: symptom management, survivorship

Interested?

Getting started is easy - When you enroll, you'll select your program and choose the time of the week that works best for you!

Keep an eye on your mail - You'll receive a Welcome Pack. It's full of resources to help you get started achieving your goals.

Get ready for your first call - Your health advisor will call you from a 205 area code.

To enroll, go to www.packhealth.com/usa or call 855-255-2362.

BLUE CROSS BLUE SHIELD ALABAMA EXTRAS

BCBS Resources Online

The BCBSAL website at www.AlabamaBlue.com offers secure access to the personal health benefit information you need most. You can create your own account and obtain real-time access to the following information and much more!

- View claim statements
- Order ID cards and view or email a virtual ID card
- See covered immunizations and preventive services
- Compare treatment costs
- Find a healthcare provider or facility
- You can also download the Alabama Blue app for your mobile devices

Prime Therapeutics

BCBSAL manages your medical benefits along with your prescription drug benefits through a partnership with Prime Therapeutics. To locate a participating Prime Network Pharmacy visit AlabamaBlue.com/PrimeParticipatingPharmacyLocator.

Maintenance drugs are available up to a 90-day supply.

Mail Order Maintenance drugs are also available through the Home Delivery Network. To enroll visit AlabamaBlue.com/HomeDeliveryNetwork.

Specialty drugs are provided through Accredo and Mitchell Cancer Institute (MCI) Pharmacy Services. With Accredo, you can expect individualized care, with experts available for complex specialty conditions as well as free shipping with safe, on-time delivery. In addition, you will have access to digital and mobile tools, including refill reminders. Mitchell Cancer Institute Pharmacy Services are also able to provide specialty medications that usually require special handling and processing.

BlueCross BlueShield of Alabama | PIVOT

Pivot first, quit when you're ready.

Pivot works even for those not ready to quit.

Pivot makes the journey easier

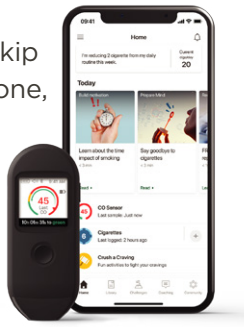
Personalized and non-judgmental, Pivot o ers a choice of tools and support.

- **Pivot App**
- **SmartSensor***
- **Free supply of Nicotine Replacement Therapy (NRT)***
- **Unlimited access to personal coaching**
- **Online community**

*NRT and the Pivot Sensor are only available to those who smoke cigarettes.

Pivot's SmartSensor

The only quit smoking program with an FDA-cleared device **to help you quit. For the first time, you can measure daily** improvements and see the impact of changes you make in real-time. Simply skip a cigarette, or delay your next one, and watch your carbon monoxide levels drop.



Clinically proven to: ⇧ motivation to quit ⇩ cigarettes per day

Get Started!

Do you want to quit smoking or help a loved one quit? **BlueCross and BlueShield of Alabama offers a great solution: Pivot.**

Scan the QR code or visit **pivot.co/bcbsal6** and use access code **bcbsal6. Need help quitting vaping?** We've got a solution for that too!

CHRONIC CONDITION MANAGEMENT PROGRAM

Enroll today in the Chronic Condition Management Program!

Call **1-888-841-5741** toll free or email

membermanagement@bcbsal.org for more information.

The Chronic Condition Management Program improves health outcomes and elevates quality of care. Registered BlueCross BlueShield nurses help you manage sometimes debilitating, chronic conditions that may be managed through early intervention and awareness of appropriate treatment and lifestyle changes.

The program focuses on five common chronic diseases:

- Asthma
- Chronic Obstructive Pulmonary Disease
- Congestive Heart Failure
- Coronary Artery Disease
- Diabetes (Types 1 and 2)

*There is no cost, and participation is completely voluntary and confidential.

The Baby Yourself Maternity Program provides support and educational materials from an experienced Blue Cross Blue Shield registered nurse. You will have access to a personal nurse you can call with questions or concerns throughout your pregnancy. If you have a high risk pregnancy, a care coordinator will help you arrange the care you need. During your pregnancy you will receive gifts to help support a healthy pregnancy.

Call **800-222-4379** to enroll in the Baby Yourself Maternity Program

Download the Baby Yourself Maternity Program app

- Daily Journal
- Photo gallery
- Weekly checklists
- Kick counter
- Contraction counter
- Hospital bag checklist
- Record scheduled doctor visits
- Daily pregnancy and parenting tips
- One-button dialing to access your physician and/or Baby Yourself Nurse*
- ...and much more!

* For this service, you must be a Blue Cross and Blue Shield of Alabama member and enrolled in the Baby Yourself Maternity Program.

FLEXIBLE SPENDING ACCOUNT (FSA)

www.healthequity.com

1-866-346-5800

SOUTHFLEX FLEXIBLE SPENDING ACCOUNTS WITH HEALTH EQUITY

What is a Flexible Spending Account?

A flexible spending account (FSA) is an account that can reimburse you for qualified health care or dependent care expenses. You can fund qualified expenses with pre-tax dollars deducted from your paychecks.

New for 2025 accounts: The grace period associated with the Health Care FSA will be eliminated and replaced with a rollover provision. Dependent Care FSAs will now provide a grace period for use of dependent care funds. See page 19 for more details.

When electing an FSA, you will set an annual contribution amount. The goal is to choose an amount that will cover medical or dependent care expenses, but that is not so high that the money will be forfeited at the end of the year.

You can choose to participate in one or both accounts, and it's not necessary to "sign up" specific family members for these accounts. Eligibility to enroll in a Health Care FSA includes benefits-eligible employees not enrolled in a USA medical plan; or for those that are enrolled in either the USA Choice Plan or USA Select Plan.

Health Care FSA

A health care FSA reimburses employees for eligible medical expenses, up to the amount contributed for the plan year. Eligible health care expenses include many of the out-of-pocket expenses you pay to maintain your health and well-being. Visit irs.gov for a full list of eligible expenses.

You may contribute up to $3,200 annually (funds will be available as of the election effective date).

Dependent Care FSA

You may use pre-tax dollars from your Dependent Care FSA to pay expenses for the care of a dependent child, spouse or elderly parent inside your home (from a qualified provider), and expenses outside your home, such as baby-sitters, nursery schools, or day care centers.

You may contribute up to $5,000 annually (or $2,500 if you are married and file a separate tax return). You can only be reimbursed up to the amount that you have contributed.

When electing your Health Care FSA contribution amount, remember to take into account the medical deductible in the USA Choice Plan and USA Select Plan.

HEALTH SAVINGS ACCOUNT (HSA)

HEALTHEQUITY

ONLY AVAILABLE TO PARTICIPANTS ENROLLED IN THE USA CONSUMER PLAN (HDHP).

A health savings account (HSA) is a tax-advantaged savings account that can be used for your qualified healthcare expenses. You own your HSA and can contribute to the account with pre-tax payroll deductions.

Did you know an HSA provides triple tax benefits? The money you contribute is pre-tax, and the interest that accumulates in the account is tax-free. In addition, money withdrawn from an HSA isn't taxed, provided you use it for qualified healthcare expenses. Like a savings account, you will only be able to withdraw funds that are in the account.

As an added benefit, USA will contribute $200 to your HSA, if you are enrolled in employee only coverage and $400 if you are enrolled in family coverage for coverage beginning January 1, 2025. A prorated contribution will be made, as applicable, for coverage that begins after January 1.

Federal law requires financial institutions to obtain information that identifies each person who opens an HSA. HealthEquity may ask you to provide proof of your identity. If you do not complete the needed identity verification, your HSA will be closed and any funds will be returned.

OTHER HSA ADVANTAGES

- You can use the account to pay for qualified healthcare expenses.
- Unspent dollars roll over each year and are yours to keep if you retire or leave the company.
- You can invest your HSA funds, so your available healthcare dollars can grow over time.

You are eligible if:

- You are enrolled in the HDHP
- You are not covered by a spouse's plan
- No one else can claim you as a dependent
- You are not enrolled in Medicare, TRICARE or TRICARE for Life
- You have not received VA benefits in the past 3 months

How Do I Access / Make Contributions to My HSA?

You can manage your HSA by visiting www.healthequity.com. You'll set up your payroll contributions during your enrollment period and can make changes at any time throughout the year (although it may take between 1–2 payroll periods for any changes to be processed).

How Much Can Be Deposited into an HSA in 2025?

<55*

- Up to $4,300 for individual
- Up to $8,550 for family

*Not enrolled in Medicare

55+*

The maximum contribution increases by $1,000

*Not enrolled in Medicare

LIMITED PURPOSE FSA

Employees enrolled in the USA Consumer Plan (HDHP) accompanied by an HSA may enroll in a Limited Purpose FSA, which reimburses dental and vision expenses. The maximum yearly contribution is $3,200. Employees will have access to their full Limited Purpose FSA contribution on the first day of the plan year. Medical expenses are not eligible for reimbursement under the Limited Purpose FSA plan.

Spending Account summary					
Account Type	Medical Plan Associated with the Account	Expenses	*Maximum Annual Election	Employer Contributions	Debit Card
Health Care FSA	PPO	Medical, Dental, and Vision	$3,200	N/A	One card for all plans
Dependent Care FSA	N/A	Dependent Care	$5,000	N/A	
Limited Purpose FSA	HDHP	Dental and Vision	$3,200	N/A	
Health Savings Account	HDHP	Medical, Dental, and Vision	$4,300/$8,550 in 2025	$200 Employee $400 Family	

*** Should you elect the current maximum FSA amount during annual enrollment and the IRS increases the above listed maximum annual elections after enrollment, you will automatically be increased to the new maximum election. If you do not want your election to automatically increase, please notify HR.**

Important Information To Know About Spending Accounts

- If you want to move to the USA Consumer Plan (HDHP), you should spend your entire Health Care FSA balance by December 31, 2024, to be eligible to contribute to the HSA.
- If 2024 Health Care FSA funds are not spent down by December 31, 2024, then you will not be eligible to contribute to your HSA until April 1, 2025.
- If you have a remaining 2024 Health Care FSA balance on January 1, 2025, you will have access to these funds through the grace period. The grace period ends on March 15, 2025.
- The Limited Purpose FSA can be used only for dental and vision expenses.

To learn more about your spending account options scan the QR code below

Health Care FSA: Rollover Added; Dependent Care FSA: New Grace Period

Starting with the 2025 plan year, we will be transitioning from the current grace period provision to a rollover provision for Health Care FSA accounts.

What This Means for You

- New Rollover Provision: With the new rollover provision, you can carry over up to $610 of unused Health Care FSA funds from the current plan year into the following year. The rollover amount will not affect your maximum election for the new plan year. For example, if you have $500 of Health Care FSA funds remaining in 2025, the $500 will rollover to your 2026 Health Care FSA account.
- Unlike the grace period, where you had to use your funds by a specific date, the rollover option allows you to carry over a limited amount automatically, providing more flexibility.
- It's important to plan your Health Care FSA contributions wisely. Any unused funds over $610 will not roll over and funds will be forfeited.
- Dependent Care flexible spending accounts will now provide a grace period for the use of dependent care funds. Participants with balances remaining at the end of 2025, will have until March 15, 2026, to incur eligible dependent care expenses, and until April 15, 2026, to file for dependent care reimbursement.

DENTAL

www.bcbsal.org

1-877-345-6171

BLUE CROSS BLUE SHIELD ALABAMA

Although you can choose any dental provider, when you use an in-network dentist, you will generally pay less. If you choose an out-of-network dentist, you may be billed the difference between what insurance pays, and what your out-of-network dentist charges for services. To locate an in-network dental provider, please visit www.bcbsal.org. Dental benefits are bundled with the USA Choice Plan, the USA Select Plan, and the USA Consumer Plan (HDHP) at no additional cost to you. Dental benefits are the same regardless of which medical plan you select.

Dental	In-network	Out-of-network
Annual deductible (Individual/Family)	$25 / $75	
Annual maximum (per person)	$1,500	
Diagnostic and preventive care Includes cleanings, fluoride treatments, sealants and x-rays	Covered at 100%	
Basic services Includes fillings, periodontics, scaling and root planning, and oral surgery	Covered at 80%	
Major services Includes crowns, bridges and full and partial dentures	Covered at 50%	

VISION

VSP

www.vsp.com

1-800-877-7195

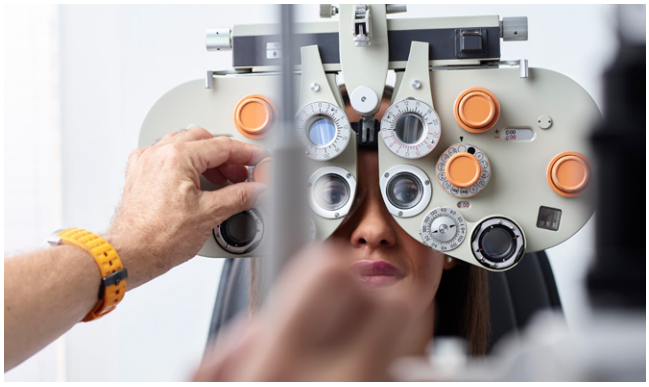
Our vision care benefits include coverage for eye exams, lenses and frames, contact lenses and discounts for laser surgery. The vision plan is built around the provider network, who have higher benefits at a lower cost to you. When you need services, consider using an in-network provider for the most bang for your buck! When you use an out-of-network provider, you will be reimbursed for services according to the grid below. Go to vsp.com to get benefit information when you need it! Once logged in, My Dashboard is your homepage. You'll find a quick view of your benefit information, access to your claim history, and you can print your Member ID Card.

If you are enrolled in the USA Choice Plan or USA Select Plan, one routine eye exam per member is covered by the Plan with a $40 office visit copay. However, there is no coverage for eyeglasses or contacts.

Vision	In-network	Out-of-network
Examination (every 12 months)		
Comprehensive Examination	$15	$45
Essential Medical Examination	$20	Not Covered
Lenses (every 12 months)		
Single	Covered at 100% after $25 Copay	$30 Allowance
Bifocal	Covered at 100% after $25 Copay	$50 Allowance
Trifocal	Covered at 100% after $25 Copay	$65 Allowance
Lenticular	Covered at 100% after $25 Copay	$100 Allowance
Frames (every 24 months)		
Frame Allowance	$150	$70
Featured Frame Brand Allowance (VSP only)	$170	Not Covered
Contact lenses (every 12 months)		
Contact Lenses Examination	$60 copay	Not Covered
Elective	$120 (not to exceed $60 copay)	$105 Allowance
Medically necessary	Covered at 100% after $25 Copay	$210 Allowance

Employees can voluntarily elect vision coverage regardless of whether they are enrolled in medical.

Scan the QR code below to download the VSP Vision Care App from the Apple App or Google Play Stores.



Your VSP vision benefits include Eyeconic.com, the VSP preferred online retailer!

Eyeconic connects your eyewear, your insurance coverage, and the VSP doctor network. Plus, you get the convenience of online shopping along with the personal touch from a VSP doctor.

Online shopping with benefits

Online shoppers will love:

- A huge selection of contact lenses and designer frames 24/7—and the Virtual Try-On tool
- Free shipping and returns
- Free frame adjustment or contact lens consultation
- Verification of your prescriptions and the 25-point inspection process to ensure your eyewear is just right

It's easy to use your VSP benefits online

1. Create an account at vsp.com. Review your vision benefit and access your eligibility and coverage information, including how to apply your benefits at Eyeconic.
2. Find superior eye care near you. The decision is yours—choose a conveniently located VSP doctor or any out-of-network provider. Visit vsp.com or call 800.877.7195 to find the best provider for you.
3. Check out Eyeconic and browse the frame brands you love. You can connect to your VSP benefits, upload your prescription at checkout, and order your glasses following your Well Vision Exam.

LIFE AND DISABILITY INSURANCE

Life Insurance

www.standard.com

1-800-247-6875

We provide Basic Group Term Life and AD&D insurance at no cost to you!

Benefits-eligible employees whose annual salary is less than $40,000 will have a flat university provided basic group term life benefit amount of $50,000.

If your salary is over $40,000, you have a university provided basic group term life benefit of 1.25 times your annual salary up to a max of $100,000.

During your new employee enrollment period, you can enroll in additional voluntary life insurance up to 1X guaranteed issue amount without needing to answer medical underwriting questions. If you choose voluntary life coverage for yourself, you can also enroll in spouse and dependent life insurance without medical underwriting. After this new employee enrollment period, medical underwriting will be required to increase your life insurance amount.

You must enroll in a minimum of 1 times voluntary additional coverage for yourself in order to elect additional spouse or child(ren) coverage.

Insurance coverage	Benefit
Voluntary life	You may choose 1, 2, or 3 times your basic life insurance amount up to $300,000. Any increases in coverage is subject to evidence of insurability.
Voluntary spouse life	If you elect voluntary coverage for yourself, you can cover your spouse for an additional $25,000.
Voluntary child(ren) life	If you elect voluntary coverage for yourself, you can cover your dependent children for an additional $10,000.

Long-Term Disability Insurance

This plan gives you income protection in the event you are ill or injured in a non-work related injury, and can't come to work.

Long-term disability benefits	
Elimination period	90 days
Monthly benefit	60% of monthly earnings
Maximum monthly benefit	Class specific monthly benefit
Maximum benefit period	SSNRA (Social Security Normal Retirement Age)

Short-Term Disability Insurance

USA Health Employees only.
Short term disability gives you income protection in the event you are ill or injured in a non-work related injury and unable to work. This benefit is only available to USA Health employees upon completion of six months of employment.

Short-term disability benefits	
Elimination period	15 days
Maximum weekly benefit	60% of your total weekly earning up to a maximum benefit of $1,000
Minimum weekly	$15
Benefit duration	up to 12 weeks

VOLUNTARY BENEFITS

www.aflacenrollment.com

800-433-3036

The University of South Alabama offers a variety of supplemental plans through Aflac for you and your family, so you can have extra financial protection to cover unexpected costs.

- Benefits are paid directly to you and you decide how to use the funds.
- Premiums are conveniently deducted from your paycheck on a post-tax basis.
- Coverage is portable.

Accident Insurance

Accident insurance pays you cash benefits depending on the covered accident you experience.

- Examples of benefits payable under the Accident plan include hospital care, physical therapy, fractures, dislocations, and burns.

How it works	
Aflac Accident Coverage is selected	**Aflac Accident insurance pays:** **$4,500***
You are injured in a car accident and transported to an emergency room by ambulance.	
You have x-rays and CT scan.	
You are diagnosed with a fractured femur and wrist and a concussion.	

Amount payable was generated based on benefit amounts for: initial treatment with x-ray ($200), Ambulance ($400), Major diagnostic testing ($200), Concussion ($300), Appliances-crutches ($100), Fracture-leg ($1,800) and Fracture-wrist ($1,500).
* Please note that the example is for illustrative purposes only. Payments may vary depending on individual circumstances and policy amounts

Hospital Indemnity Insurance

Hospitalizations can be costly, even with medical insurance. Hospital indemnity insurance provides extra financial support to help you cover your out-of-pocket expenses.

- You are paid cash benefits based on your inpatient hospital stay.
- Additional benefits available for utilizing a USA Health facility.
- Benefits are paid regardless of medical insurance coverage.

How it works	
Aflac Group Hospital Indemnity coverage is selected.	**Aflac Group Hospital Indemnity plan pays:** **$1,800***
The insured has a high fever and goes to the emergency room.	
The physician admits the insured into the hospital.	
The insured is released after two days.	

*Please note that the example is for illustrative purposes only. Payments may vary depending on individual circumstances and policy amounts.

Critical Illness Insurance

If you are diagnosed with a serious illness, such as cancer, heart attack, or stroke, you may need extra financial support to cover the costs for your care. Critical Illness Insurance pays a lump sum upon diagnosis of a covered illness.

- You may purchase coverage in $10,000 increments to a maximum of $40,000.
- The amount you pay is based on your age and coverage.
- Coverage for your spouse may also be purchased in the same amount if you elect coverage for yourself.
- Dependent children are covered at no extra cost.

Your coverage also includes a $50 annual Health Screening benefit for having a preventive exam, such as a physical exam, pap smear, or PSA test. This benefit is payable once per calendar year, per insured. See your Plan Summary for more information.

How it works	
Aflac Group Critical Illness coverage is selected.	**Aflac Group Critical Illness pays an Initial Diagnosis Benefit of:** **$10,000***
You experience chest pains and numbness in the left arm.	
You visit the emergency room.	
A physician determines that you have suffered a heart attack.	

Amount payable based on $10,000 Initial Diagnosis benefit and the coverage amount selected at time of enrollment.
*Please note that the example is for illustrative purposes only. Payments may vary depending on individual circumstances and policy amounts.

Group Life Term to 120 Insurance

This Group Term Life insurance plan will stay with you through retirement — all the way to age 120! This plan has no benefit reduction once you reach age 65 like many plans do. Upon diagnosis of a terminal illness, you have the flexibility to choose how to receive your payout – either 50% of the plan coverage amount in a lump sum or periodic payments in the amount of 4% of the life benefit. Coverage is available for you, your spouse, and your dependent child(ren).

Group Accident, Critical Illness, Hospital Indemnity and Term Life insurance are underwritten by Continental American Insurance Company (CAIC), a proud member of the Aflac family of insurers. CAIC is not licensed to solicit business in New York, Guam, Puerto Rico, or the Virgin Islands. This is a brief product overview only. The plans have limitations and exclusions that affect benefits payable. Refer to the plans for complete details. AGC2300868 EXP 7/25

Scan for more information on the Aflac Plans

ADDITIONAL BENEFITS FROM THE STANDARD

Life Services Toolkit

The Life Services Toolkit provides online resources and tools to support you and your beneficiaries with your group life insurance through The Standard. Online tools and services can help you create a will, make advance funeral plans, and put your finances in order. After a loss, your beneficiary can consult experts by phone or in person, and obtain helpful information online.

Beneficiaries can participate in phone consultations or in-person meetings with trained grief counselors.

For beneficiary services, visit standard.com/mytoolkit (user name: support) or call the assistance line at 800-378-5742

Services to Help You Now

Visit the Life Services Toolkit website at standard.com/mytoolkit and enter username "assurance" for information and tools to help you make important life decisions.

Life Service can help you with:

- Estate Planning Assistance
- Financial Planning
- Health and Wellness
- Identity Theft Prevention
- Funeral Arrangements

Life Services can help your beneficiaries with:

- Grief Support
- Legal Services
- Financial Assistance
- Support Services
- Online Resources

Travel Assistance

Things can happen on the road. Passports get stolen or lost. Unforeseen events or circumstances derail travel plans. Medical problems surface at the most inconvenient times. Travel Assistance can help you navigate these issues and more at any time day or night.

Security That Travels With You

Travel assistance is available when you travel more than 100 miles from home or internationally for up to 180 days. Secure travel assistance offers aid before and during your trip that includes:

- Visa, weather and currency exchange information
- Country specific security and travel advisories
- Credit card and passport replacement
- Missing baggage and emergency cash coordination
- Help replacing lost prescription medication and advancing funding for hospital admission
- Emergency evacuation to the nearest adequate medical facility
- Connection to medical care providers, interpreter services and local attorneys
- Return travel companion if travel is disrupted due to emergency transportation services or care of minor children left unattended due to prolonged hospitalization
- Evacuation arrangements in the event of a natural disaster, political unrest and social instability

Contact Travel Assistance

800-872-1414 if in United States, Puerto Rico U.S. Virgin Islands and Bermuda

Everywhere else 609-986-1234
Text: 609-334-0807
Email – medservices@assistamerica.com

ADDITIONAL EMPLOYER PROVIDED BENEFITS

Employee Assistance Program (EAP)

The EAP offers confidential counseling and referral services at no cost to you. University General Division employees (main campus) can call the EAP at (251) 460-6133. USA Health employees may call the EAP at (251) 415-1604.

Educational Benefit Plan

Upon completion of 6 months of employment prior to the first day of classes per the University Academic Calendar, if you are a regular benefits-eligible employee working .90 FTE or greater, you may qualify for a tuition credit for up to five semester hours, plus the University registration fee. The tuition credit rate is based on the prevailing College of Arts and Sciences undergraduate tuition rate for all course levels. You must maintain at least a 2.0 institutional grade-point average for undergraduate course work and a 3.0 institutional grade-point average for graduate course work for continued eligibility.

Tuition credit is also available to your spouse and unmarried dependent children (under age 25 on the first day of classes), if you are eligible for the educational benefit. The tuition credit is 50% of tuition only (no fees) with no hour maximum. The tuition credit rate is based on the prevailing College of Arts and Sciences undergraduate tuition rate for all course levels. Your spouse/dependent children must maintain at least a 2.0 institutional grade-point average for undergraduate course work and a 3.0 institutional grade-point average for graduate course work for continued eligibility.

PROFESSIONAL RETIREMENT INVESTMENT ADVICE WITH TIAA

Your Retirement Plan With TIAA Comes With Retirement Investment Advice- At No Additional Cost

- The investment fund recommendations are provided by an independent third-party financial expert, Morningstar Investment Management, LLC, and cover all available investments in your TIAA retirement plan.
- You can access this advice online through our Retirement Advisor tool or by visiting with a TIAA financial consultant in person.
- The arrangement with Morningstar provides unbiased advice on all of the funds we recordkeep on our platform, including proprietary products such as TIAA Traditional, as well as nonproprietary investment options.

Access advice online, in person, or by phone!

To set up your advice session, visit TIAA Secure Account Access or call **800-732-8353**

You can also try our easy-to-use Retirement Advisor tool. Just go to

Consultations and Seminars | TIAA and log in to your account.

Our client-centric retirement investment advice is consistent with TIAA's investment philosophy, which emphasizes investing for the long term and is designed to address the specific retirement needs of each employee.

Introducing SAVI:

You and your family members have access to Savi, a robust tool that helps you find the best federal repayment and forgiveness programs for your financial situation. Borrowers working with Savi can save an average of $187 on their monthly student loan payments!

You can unlock a world of options with Savi's three distinct plan levels.

- DIY: Dive in with free access to a personalized repayment calculator, forgiveness detection, and Savi workshops.
- Essential: Step up to a premium tier! Have access to digitized applications and enjoy the comfort of one-on-one customer support.
- Pro: Elevate your experience with a personalized onboarding session and dedicated Savi phone support.

Get started today at:

TIAA.org/southalabama/student

TIAA.org/usahca/student

TIAA.org/usahm/student

FEED YOUR HEALTH, NOURISH YOUR FUTURE

SAVOR THE FLAVOR OF GOOD HEALTH

Indulge in the taste of nutritious, budget-friendly meals that prioritize your well-being without compromising on flavor.

COOK YOUR WAY TO BETTER HEALTH

Join our expert instructors in hands-on cooking classes focused on preparing dishes that benefit your body and your taste buds.

Are you ready to cook up something good – and healthy with us?
***$10 per series of four classes, *$5 per demo**

SIGN UP TODAY AT USAHEALTHSYSTEM.COM/CULINARYMEDICINE

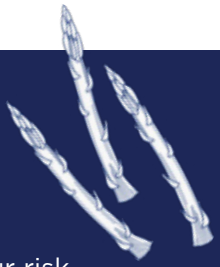
*eligibility limited to employees enrolled in the USA Health & Dental Plans

Discover the transformative power of culinary wellness at the University of South Alabama! The USA Health Integrative Health and Wellness program is offering new cooking classes that provide a delicious solution to combating many health risks in a world where 8 out of 10 causes of death and chronic diseases are lifestyle-related.

We believe that a healthy kitchen is a happy kitchen. Say goodbye to processed foods filled with harmful chemicals and preservatives, and say hello to natural, wholesome ingredients that nourish your body and delight your taste buds. Embrace a Southern, Mediterranean, or Asian-inspired diet that tastes amazing and supports optimal health.

By making just a few changes to your weekly meal preparation, you can significantly reduce your risk of developing chronic diseases like type 2 diabetes, hypertension, heart disease, and more. A healthier you means a happier and wealthier you, and the University is here to support your journey to wellness.

Join our expert healthcare providers in our teaching kitchens located in Mobile and Fairhope and learn essential culinary skills, from chopping veggies to creating nutritious breakfast options. Empower yourself to take control of your health and well-being by participating in our Integrative Health and Wellness Program.



TRANSFORM YOUR LIFESTYLE

Make small changes to your cooking habits to reduce your risk of chronic diseases and improve your overall quality of life.

INVEST IN YOUR HEALTH

Enroll in our culinary wellness program to take the first step towards a healthier, happier you. USA is committed to supporting your well-being journey.

JagFIT@SOUTH

Move More, Fuel Smart, Stress Less, Live Healthy

We want to encourage you to Move Your Body, Fuel Smart, Stress Less, and Live Healthy. The University of South Alabama is dedicated to your well-being and we encourage you to take advantage of the health and wellness opportunities available. Log on to www.southalabama.edu/JagFit **to learn more about the JagFit Wellness program.**

Join the movement!

Trek Talk – is a unique approach to get your body moving. Trek talk combines a 30 minute lunchtime walk while engaging with an interesting speaker during the walk. We invite you to join us! All that is required is for you to pack your sneakers and join us at our next Trek Talk!

Health Challenges – Join a health challenge to keep up with your fitness. We offer walking and running challenges, mindfulness challenges, and even fun games like bingo to keep you motivated.

Stress Less - The Student Recreation Center offers yoga classes to strengthen your mind, body, and spirit. Join today!

SouthFit – Join The SouthFit Program and check out one of the many programs offered. We have something for everyone from Group Fitness Classes, Personal Training, Fitness Certifications, Workshops, and Education. We want to help you reach your health and fitness goals!

PAYROLL CONTRIBUTIONS

Medical/Dental/Rx

Type of Coverage	USA Choice Plan Base Premium	USA Choice Plan Standard Premium	USA Select Plan	USA Consumer Plan (HDHP)
Single	$137.00	$157.00	$103.00	$50.00
Family	$454.00	$518.00	$339.00	$250.00

* Includes the $50 per month non-tobacco use wellness incentive

Vision

Type of Coverage	VSP Vision
Single	$7.18
Family	$19.82

- Insurance premiums are deducted one month in advance for Medical, Vision and Voluntary Life Insurance.
- Voluntary Life insurance premiums are deducted monthly from the first paycheck of the month.

Voluntary Life Insurance

(see page 22 for additional details and underwriting requirements)

Employee Age on January 1	Rate (per $1,000 of Total Coverage)
0-24	$0.050
25-29	$0.060
30-34	$0.080
35-39	$0.090
40-44	$0.140
45-49	$0.210
50-54	$0.330
55-59	$0.480
60-64	$0.740
65-69	$1.270
70-74	$3.850
75-999	$3.850

To calculate your premium

	÷ $1,000 =		x $		= $	
Amount Elected				From Chart		Your Monthly Cost

Dependent Coverage	Monthly Premium
Spouse	$8.32
Child(ren)	$3.00

	Health Savings Account Funding			
Coverage effective date	paid date monthly	paid date biweekly	single	family
1-Jan	1-Feb	2nd BW of Jan	$200.00	$400.00
1-Feb	1-Mar	2nd BW of Feb	$200.00	$400.00
1-Mar	1-Apr	2nd BW of Mar	$200.00	$400.00
1-Apr	1-May	2nd BW of April	$150.00	$300.00
1-May	1-Jun	2nd BW of May	$150.00	$300.00
1-Jun	1-Jul	2nd BW of June	$150.00	$300.00
1-Jul	1-Aug	2nd BW of July	$100.00	$200.00
1-Aug	1-Sep	2nd BW of Aug	$100.00	$200.00
1-Sep	1-Oct	2nd BW of Sept	$100.00	$200.00
1-Oct	1-Nov	2nd BW of Oct	$50.00	$100.00
1-Nov	1-Dec	2nd BW of Nov	$50.00	$100.00
1-Dec	1-Jan	2nd BW of Dec	$50.00	$100.00

GLOSSARY OF TERMS

COPAYMENT: A copayment (copay) is the fixed dollar amount you pay for certain in-network services on a PPO-type plan. In some cases, you may be responsible for coinsurance after a copay is made.

COINSURANCE: Your share of the costs of a healthcare service, usually figured as a percentage of the amount charged for services. You start paying coinsurance after you've met the deductible. Your plan pays a certain percentage of the total bill, and you pay the remaining percentage.

DEDUCTIBLE: A deductible is the amount of money you must meet before your plan begins paying for services covered by coinsurance. Some services, such as office visits that require copays do not apply to the deductible. For example, if your plan's deductible is $1,000, you'll pay 100 percent of eligible healthcare expenses until you have met the $1,000 deductible. After that, you share the cost with your plan by paying coinsurance.

FORMULARY: A list of prescription drugs covered by the plan. Also called a drug list.

IN-NETWORK: A group of doctors, clinics, hospitals and other healthcare providers that have an agreement with your medical plan provider. You pay a negotiated rate for services when you use in-network providers.

OUT-OF-NETWORK: Care received from a doctor, hospital or other provider that is not part of the plan agreement. You'll pay more when you use out-of-network providers since they don't have a negotiated rate with your plan provider. You may also be billed the difference between what the out-of-network provider charges for services and what the plan provider pays for those services.

OUT-OF-POCKET MAXIMUM: This is the most you must pay for covered services in a plan year. After you spend this amount on deductibles and coinsurance, your health plan pays 100 percent of the costs of covered benefits. However, you must pay for certain out-of-network charges above reasonable and customary amounts.

VESTING: A participant's right of ownership to the money in his or her plan account. A participant's contributions and their earnings are always 100% vested; however, employer matching contributions may become vested over a period of time.

EVIDENCE OF INSURABILITY (EOI): The application process in which you provide information on the condition of your health or your dependents' health in order to be approved for coverage.

HEALTH SAVINGS ACCOUNT: an account that you can use to pay for qualified medical expenses that are subject to your deductible.

HIGH DEDUCTIBLE HEALTH PLAN: a type of medical plan that requires the member to reach a deductible prior to having services covered by coinsurance.

LIMITED PURPOSE FSA: a tax advantaged account used for eligible dental and vision expenses; it is designed to be paired with an HSA and HDHP.

FLEXIBLE SPENDING ACCOUNT: a tax -advantaged account that allows employees to set aside pre-tax earnings to pay for qualified medical expenses; this is designed to be paired with a PPO plan.

DEPENDENT CARE FSA: a tax-advantaged that allows employees to set aside pre-tax earnings specifically to pay for eligible dependent care expenses.

USA CHOICE, USA SELECT & USA CONSUMER HDHP HEALTH PLAN NOTICES

TABLE OF CONTENTS

IMPORTANT NOTICE

This packet of notices related to our health care plan includes a notice regarding how the plan's prescription drug coverage compares to Medicare Part D. If you or a covered family member is also enrolled in Medicare Parts A or B, but not Part D, you should read the Medicare Part D notice carefully. It is titled, "Important Notice From University of South Alabama About Your Prescription Drug Coverage and Medicare."

IMPORTANT NOTICE FROM USA HEALTH & DENTAL PLANS – USA CHOICE, USA SELECT & USA CONSUMER HDHP (USA PLAN) ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with USA Employee Health Care and about your options under Medicare's prescription drug coverage. This information can help you decide whether you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

If neither you nor any of your covered dependents are eligible for or have Medicare, this notice does not apply to you or your dependents, as the case may be. However, you should still keep a copy of this notice in the event you or a dependent should qualify for coverage under Medicare in the future. Please note, however, that later notices might supersede this notice.

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. USA has determined that the prescription drug coverage offered by the USA Employee Health Care Plan ("Plan") is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is considered "creditable" prescription drug coverage. This is important for the reasons described below.

   Because your existing coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to enroll in a Medicare drug plan, as long as you later enroll within specific time periods.

   Enrolling in Medicare—General Rules
   As some background, you can join a Medicare drug plan when you first become eligible for Medicare. If you qualify for Medicare due to age, you may enroll in a Medicare drug plan during a seven-month initial enrollment period. That period begins three months prior to your 65th birthday, includes the month you turn 65, and continues for the ensuing three months. If you qualify for Medicare due to disability or end-stage renal disease, your initial Medicare Part D enrollment period depends on the date your disability or treatment began. For more information you should contact Medicare at the telephone number or web address listed below.

   Late Enrollment and the Late Enrollment Penalty
   If you decide to *wait* to enroll in a Medicare drug plan you may enroll later, during Medicare Part D's annual enrollment period, which runs each year from October 15 through December 7. But as a general rule, if you delay your enrollment in Medicare Part D, after first becoming eligible to enroll, you may have to pay a higher premium (a penalty).

   If after your initial Medicare Part D enrollment period you go **63 continuous days or longer without "creditable" prescription drug coverage** (that is, prescription drug coverage that's at least as good as Medicare's prescription drug coverage), your monthly Part D premium may go up by at least 1 percent of the premium you would have paid had you enrolled timely, for every month that you did not have creditable coverage. For example, if after your Medicare Part D initial enrollment period you go 19 months without coverage, your premium may be at least 19% higher than the premium you otherwise would have paid. You may have to pay this higher premium for as long as you have Medicare prescription drug coverage. *However, there are some important exceptions to the late enrollment penalty.*

   Special Enrollment Period Exceptions to the Late Enrollment Penalty
   There are "special enrollment periods" that allow you to add Medicare Part D coverage months or even years after you first became eligible to do so, without a penalty. For example, if after your Medicare Part D initial enrollment period you lose or decide to leave employer-sponsored or union-sponsored health coverage that includes "creditable" prescription drug coverage, you will be eligible to join a Medicare drug plan at that time. In addition, if you otherwise lose other creditable prescription drug coverage (such as under an individual policy)

through no fault of your own, you will be able to join a Medicare drug plan, again without penalty. These special enrollment periods end two months after the month in which your other coverage ends.

Compare Coverage
You should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. See the USA Plan's summary plan description for a summary of the Plan's prescription drug coverage. If you don't have a copy, you can get one by contacting us at the telephone number or address listed below.

Coordinating Other Coverage With Medicare Part D
Generally speaking, if you decide to join a Medicare drug plan while covered under the USA Plan due to your employment (or someone else's employment, such as a spouse or parent), your coverage under the USA Plan will not be affected. For most persons covered under the Plan, the Plan will pay prescription drug benefits first, and Medicare will determine its payments second. For more information about this issue of what program pays first and what program pays second, see the Plan's summary plan description or contact Medicare at the telephone number or web address listed below.If you do decide to join a Medicare drug plan and drop your USA Plan prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back. To regain coverage you would have to re-enroll in the Plan, pursuant to the Plan's eligibility and enrollment rules. You should review the Plan's summary plan description to determine if and when you are allowed to add coverage.

For More Information About This Notice or Your Current Prescription Drug Coverage…
Contact the person listed below for further information, or call (251) 460-6133. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through USA changes. You also may request a copy.

For More Information About Your Options Under Medicare Prescription Drug Coverage…
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.
For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov.
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and whether or not you are required to pay a higher premium (a penalty).

Date: October 14, 2024
Name of Entity/Sender: Tina Stalmach
Contact—Position/Office: Senior Director, Human Resources
Address: 650 Clinic Drive, TRP Bldg III, Ste 2200 Mobile, AL 36688
Phone Number: (251) 460-6133

Nothing in this notice gives you or your dependents a right to coverage under the Plan. Your (or your dependents') right to coverage under the Plan is determined solely under the terms of the Plan.

HIPAA COMPREHENSIVE NOTICE OF PRIVACY POLICY AND PROCEDURES
USA HEALTH & DENTAL PLANS – USA CHOICE, USA SELECT & USA CONSUMER HDHP
IMPORTANT NOTICE COMPREHENSIVE NOTICE OF PRIVACY POLICY AND PROCEDURES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice is provided to you on behalf of: **University of South Alabama, USA HealthCare Management, LLC and USA Health Care Authority**

* This notice pertains only to healthcare coverage provided under the plan.

For the remainder of this notice, University of South Alabama is referred to as Company.

1. Introduction: This Notice is being provided to all covered participants in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and is intended to apprise you of the legal duties and privacy practices of the Company's self-insured group health plans. If you are a participant in any fully insured group health plan of the Company, then the insurance carriers with respect to those plans is required to provide you with a separate privacy notice regarding its practices.

2. General Rule: A group health plan is required by HIPAA to maintain the privacy of protected health information, to provide individuals with notices of the plan's legal duties and privacy practices with respect to protected health information, and to notify affected individuals follow a breach of unsecured protected health information. In general, a group health plan may only disclose protected health information (i) for the purpose of carrying out treatment, payment and health care operations of the plan, (ii) pursuant to your written authorization; or (iii) for any other permitted purpose under the HIPAA regulations.

3. Protected Health Information: The term "protected health information" includes all individually identifiable health information transmitted or maintained by a group health plan, regardless of whether or not that information is maintained in an oral, written or electronic format. Protected health information does not include employment records or health information that has been stripped of all individually identifiable information and with respect to which there is no reasonable basis to believe that the health information can be used to identify any particular individual.

4. Use and Disclosure for Treatment, Payment and Health Care Operations*:* A group health plan may use protected health information without your authorization to carry out treatment, payment and health care operations of the group health plan.

- An example of a "treatment" activity includes consultation between the plan and your health care provider regarding your coverage under the plan.
- Examples of "payment" activities include billing, claims management, and medical necessity reviews.
- Examples of "health care operations" include disease management and case management activities.

The group health plan may also disclose protected health information to a designated group of employees of the Company, known as the HIPAA privacy team, for the purpose of carrying out plan administrative functions, including treatment, payment and health care operations.

If protected health information is properly disclosed under the HIPAA Privacy Practices, such information may be subject to redisclosure by the recipient and no longer protected under the HIPAA Privacy Practices.

5. Disclosure for Underwriting Purposes. A group health plan is generally prohibited from using or disclosing protected health information that is genetic information of an individual for purposes of underwriting.

6. Uses and Disclosures Requiring Written Authorization: Subject to certain exceptions described elsewhere in this Notice or set forth in regulations of the Department of Health and Human Services, a group health plan may not disclose protected health information for reasons unrelated to treatment, payment or health care operations without your authorization. Specifically, a group health plan may not use your protected health information for marketing purposes or sell your protected health information. Any use or disclosure not disclosed in this Notice will be made only with your written authorization. If you authorize a disclosure of protected health information, it will be disclosed solely for the purpose of your authorization and may be revoked at any time. Authorization forms are available from the Privacy Official identified in section 23.

7. Special Rule for Mental Health Information: Your written authorization generally will be obtained before a group health plan will use or disclose psychotherapy notes (if any) about you.

8. Uses and Disclosures for which Authorization or Opportunity to Object is not Required: A group health plan may use and disclose your protected health information without your authorization under the following circumstances:When required by law;

- When permitted for purposes of public health activities;
- When authorized by law to report information about abuse, neglect or domestic violence to public authorities;
- When authorized by law to a public health oversight agency for oversight activities (subject to certain limitation described in paragraph 20 below);
- When required for judicial or administrative proceedings (subject to certain limitation described in paragraph 20 below);
- When required for law enforcement purposes (subject to certain limitation described in paragraph 20 below);
- When required to be given to a coroner or medical examiner or funeral director (subject to certain limitation described in paragraph 20 below);
- When disclosed to an organ procurement organization;
- When used for research, subject to certain conditions;
- When necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat; and
- When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

9. Minimum Necessary Standard: When using or disclosing protected health information or when requesting protected health information from another covered entity, a group health plan must make reasonable efforts not to use, disclose or request more than the minimum amount of protected health information necessary to accomplish the intended purpose of the use, disclosure or request. The minimum necessary standard will not apply to: disclosures to or requests by a health care provider for treatment; uses or disclosures made to the individual about his or her own protected health information, as permitted or required by HIPAA; disclosures made to the Department of Health and Human Services; or uses or disclosures that are required by law.

10. Disclosures of Summary Health Information: A group health plan may use or disclose summary health information to the Company for the purpose of obtaining premium bids or modifying, amending or **t**erminating the group health plan. Summary health information summarizes the participant claims history and other information without identifying information specific to any one individual.

11. Disclosures of Enrollment Information: A group health plan may disclose to the Company information on whether an individual is enrolled in or has disenrolled in the plan.

12. Disclosure to the Department of Health and Human Services: A group health plan may use and disclose your protected health information to the Department of Health and Human Services to investigate or determine the group health plan's compliance with the privacy regulations.

13. Disclosures to Family Members, other Relations and Close Personal Friends: A group health plan may disclose protected health information to your family members, other relatives, close personal friends and anyone else you choose, if: (i) the information is directly relevant to the person's involvement with your care or payment for that care, and (ii) either you have agreed to the disclosure, you have been given an opportunity to object and have not objected, or it is reasonably inferred from the circumstances, based on the plan's common practice, that you would not object to the disclosure.

For example, if you are married, the plan will share your protected health information with your spouse if he or she reasonably demonstrates to the plan and its representatives that he or she is acting on your behalf and with your consent. Your spouse might to do so by providing the plan with your claim number or social security number. Similarly, the plan will normally share protected health information about a dependent child (whether or not emancipated) with the child's parents. The plan might also disclose your protected health information to your family

members, other relatives, and close personal friends if you are unable to make health care decisions about yourself due to incapacity or an emergency.

14. Appointment of a Personal Representative: You may exercise your rights through a personal representative upon appropriate proof of authority (including, for example, a notarized power of attorney). The group health plan retains discretion to deny access to your protected health information to a personal representative.

15. Individual Right to Request Restrictions on Use or Disclosure of Protected Health Information: You may request the group health plan to restrict (1) uses and disclosures of your protected health information to carry out treatment, payment or health care operations, or (2) uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. However, the group health plan is not required to and normally will not agree to your request in the absence of special circumstances. A covered entity (other than a group health plan) must agree to the request of an individual to restrict disclosure of protected health information about the individual to the group health plan, if (a) the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law, and (b) the protected health information pertains solely to a health care item or service for which the individual (or person other the health plan on behalf of the individual) has paid the covered entity in full.

16. Individual Right to Request Alternative Communications: The group health plan will accommodate reasonable written requests to receive communications of protected health information by alternative means or at alternative locations (such as an alternative telephone number or mailing address) if you represent that disclosure otherwise could endanger you. The plan will not normally accommodate a request to receive communications of protected health information by alternative means or at alternative locations for reasons other than your endangerment unless special circumstances warrant an exception.

17. Individual Right to Inspect and Copy Protected Health Information: You have a right to inspect and obtain a copy of your protected health information contained in a "designated record set," for as long as the group health plan maintains the protected health information. A "designated record set" includes the medical records and billing records about individuals maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan; or other information used in whole or in part by or for the group health to make decisions about individuals.

The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the group health plan is unable to comply with the deadline. If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise those review rights and a description of how you may contact the Secretary of the U.S. Department of Health and Human Services.

18. Individual Right to Amend Protected Health Information: You have the right to request the group health plan to amend your protected health information for as long as the protected health information is maintained in the designated record set. The group health plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the group health plan is unable to comply with the deadline. If the request is denied in whole or part, the group health plan must provide you with a written denial that explains the basis for the denial. You may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your protected health information.

19. Right to Receive an Accounting of Protected Health Information Disclosures: You have the right to request an accounting of all disclosures of your protected health information by the group health plan during the six years prior to the date of your request. However, such accounting need not include disclosures made: (1) to carry out treatment, payment or health care operations; (2) to individuals about their own protected health information; (3) prior to the compliance date; or (4) pursuant to an individual's authorization.

If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided. If you request more than one accounting within a 12-month period, the group health plan may charge a reasonable fee for each subsequent accounting.

20. Reproductive Health Care Privacy: Effective December 22, 2024, a group health plan may not disclose protected health information to: (i) conduct a criminal, civil, or administrative investigation into a person for the mere act of seeking, obtaining, providing, or facilitating reproductive health care; (ii) impose criminal, civil, or administrative liability on any person for the mere act of seeking, obtaining, providing, or facilitating reproductive health care; or (iii) identify any person for the purposes described in (i) and (ii).

Reproductive health care means care, services, or supplies related to the reproductive health of the individual.

This prohibition only applies if the reproductive health care is lawful under the law of the state in which the health care was provided and under the circumstances in which it was provided, or if the reproductive health care was protected, required, or authorized by Federal law, including the United States Constitution, regardless of the state in which it is provided. For example, if you receive reproductive health care in a state where such care is lawful even though it is not lawful in the state where you reside, the plan may not disclose this information to conduct an investigation.

A group health plan may not use or disclose protected health information potentially related to reproductive health care for the purposes of uses and disclosures of 1) public health oversight activities, 2) judicial and administrative proceedings, 3) law enforcement purposes, and 4) coroners and medical examiners without obtaining a valid attestation from the person requesting the use or disclosure of such information. A valid attestation under this section must include the following elements:

(i) A description of the information requested that identifies the information in a specific fashion, including one of the following: (A) the name of any individual(s) whose protected health information is sought, if practicable; and (B) if including the name(s) of any individual(s) whose protected health information is sought is not practicable, a description of the class of individuals whose protected health information is sought.

(ii) The name or other specific identification of the person(s), or class of persons, who are requested to make the use or disclosure.

(iii) The name or other specific identification of the person(s), or class of persons, to whom the covered entity is to make the requested use or disclosure.

(iv) A clear statement that the use or disclosure is not for a purpose prohibited by the reproductive health care regulation.

(v) A statement that a person may be subject to criminal penalties if that person knowingly and in violation of HIPAA obtains individually identifiable health information relating to an individual or discloses individually identifiable health information to another person.

(vi) Signature of the person requesting the protected health information, which may be an electronic signature, and date. If the attestation is signed by a representative of the person requesting the information, a description of such representative's authority to act for the person must also be provided.

For example, if you lawfully obtain an abortion and an investigation into the provider is conducted, law enforcement would need to submit an attestation in order to try and obtain the information. The plan would deny the request per HIPAA's prohibition on the disclosure of reproductive health care because such care was lawful.

21. The Right to Receive a Paper Copy of This Notice Upon Request: If you are receiving this Notice in an electronic format, then you have the right to receive a written copy of this Notice free of charge by contacting the Privacy Official (see section 24).

22. Changes in the Privacy Practice. Each group health plan reserves the right to change its privacy practices from time to time by action of the Privacy Official. You will be provided with an advance notice of any material change in the plan's privacy practices.

23. Your Right to File a Complaint with the Group Health Plan or the Department of Health and Human Services: If you believe that your privacy rights have been violated, you may complain to the group health plan in care of the HIPAA Privacy Official (see section 24). You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue S.W., Washington, D.C. 20201. The group health plan will not retaliate against you for filing a complaint.

24. Person to Contact at the Group Health Plan for More Information: If you have any questions regarding this Notice or the subjects addressed in it, you may contact the Privacy Official.

Privacy Official

The Plan's Privacy Official, the person responsible for ensuring compliance with this notice, is:
Tina Stalmach Senior Director, Human Resources
(251) 460-6133
The Plan's Deputy Privacy Official(s) is/are: Tina Stalmach
Senior Director, Human Resources
(251) 460-6133

Effective Date
The effective date of this notice is: October 14, 2024.

NOTICE OF SPECIAL ENROLLMENT RIGHTS

USA HEALTH & DENTAL PLANS – USA CHOICE, USA SELECT & USA CONSUMER HDHP EMPLOYEE HEALTH CARE PLAN

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to later enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage).

Loss of eligibility includes but is not limited to:

- Loss of eligibility for coverage as a result of ceasing to meet the plan's eligibility requirements (e.g., divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment);
- Loss of HMO coverage because the person no longer resides or works in the HMO service area and no other coverage option is available through the HMO plan sponsor;
- Elimination of the coverage option a person was enrolled in, and another option is not offered in its place;
- Failing to return from an FMLA leave of absence; and
- Loss of eligibility under Medicaid or the Children's Health Insurance Program (CHIP).

Unless the event giving rise to your special enrollment right is a loss of eligibility under Medicaid or CHIP, you must request enrollment within *30 days* after your or your dependent's(s') other coverage ends (or after the employer that sponsors that coverage stops contributing toward the coverage).

If the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you may request enrollment under this plan within ***60 days*** of the date you or your dependent(s) lose such coverage under Medicaid or CHIP. Similarly, if you or your dependent(s) become eligible for a state-granted premium subsidy toward this plan, you may request enrollment under this plan within ***60 days*** after the date Medicaid or CHIP determine that you or the dependent(s) qualify for the subsidy.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within *30 days* after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact:

Tina Stalmach
Senior Director, Human Resources
(251) 460-6133

GENERAL COBRA NOTICE

Introduction
You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must 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 the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?
The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice in writing to the Plan Administrator. Any notice you provide must state the name of the plan or plans under which you lost or are losing coverage, the name and address of the employee covered under the plan, the name(s) and address(es) of the qualified beneficiary(ies), and the qualifying event and the date it happened. The Plan Administrator will direct you to provide the appropriate documentation to show proof of the event.

How is COBRA continuation coverage provided?
Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.
COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:
Disability extension of 18-month period of COBRA continuation coverage
If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. If you believe you are eligible for this extension, contact the Plan Administrator.

Second qualifying event extension of 18-month period of continuation coverage
If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?
Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), 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 continuation coverage. You can learn more about many of these options at **www.healthcare.gov**.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?
In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.
For more information visit https://www.medicare.gov/medicare-and-you.

If you have questions
Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit **www.dol.gov/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.HealthCare.gov**.
Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.
Plan contact information

For additional information regarding your COBRA continuation coverage rights, please contact the Plan Administrator below:

Tina Stalmach
Senior Director, Human Resources
650 Clinic Drive, TRP Bldg III, Ste 2200
Mobile, AL 36688
(251) 460-6133

WOMEN'S HEALTH AND CANCER RIGHTS NOTICE

USA Health Plans – USA Choice, USA Select & USA Consumer HDHP Employee Health Care Plan is required by law to provide you with the following notice:

The Women's Health and Cancer Rights Act of 1998 ("WHCRA") provides certain protections for individuals receiving mastectomy-related benefits. Coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedemas.

USA Health Plans – USA Choice, USA Select & USA Consumer HDHP Employee Health Care Plan provide(s) medical coverage for mastectomies and the related procedures listed above, subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply:

USA Choice Plan	USA Health Network & BCBS Network	Out-of-Network
Individual Deductible	$125	$250
Family Deductible	$250	$500
Coinsurance	0%	20%
USA Select Plan	USA Health Network & BCBS Network	Out-of-Network
Individual Deductible	$125	Not Covered
Family Deductible	$250	Not Covered
Coinsurance	0% to 30%	Not Covered
USA Consumer HDHP Plan	USA Health Network & BCBS Network	Out-of-Network
Individual Deductible	$2,000	$4,000
Family Deductible	$4,000	$8,000
Coinsurance	20% to 25%	30%

If you would like more information on WHCRA benefits, please refer to your Summary Plan Description located at www.southalabama.edu/hr or contact your Plan Administrator at 877-345-6171.

Tina Stalmach
Senior Director, Human Resources
(251) 460-6133

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.govto find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2024. Contact your State for more information on eligibility –

ALABAMA – Medicaid	**COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442
ALASKA – Medicaid	**FLORIDA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx	Website:https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
ARKANSAS – Medicaid	**GEORGIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: (678) 564-1162, Press 2
CALIFORNIA – Medicaid	**INDIANA – Medicaid**
Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov	Health Insurance Premium All other Medicaid Website: https://www.in.gov/medicaid/http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)	MONTANA – Medicaid
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human ServicesHawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov
KANSAS – Medicaid	**NEBRASKA – Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
KENTUCKY – Medicaid	**NEVADA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
LOUISIANA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
MAINE – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Enrollment Website https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)
MASSACHUSETTS – Medicaid and CHIP	**NEW YORK – Medicaid**
Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	**NORTH CAROLINA – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
MISSOURI – Medicaid	**NORTH DAKOTA – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**UTAH – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/

OREGON – Medicaid	VERMONT– Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075	Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
RHODE ISLAND – Medicaid and CHIP	**WASHINGTON – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
SOUTH CAROLINA – Medicaid	**WEST VIRGINIA – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: https://dhhr.wv.gov/bms/ https://www.mywvhipp.com/ Medicaid Phone: 304-558-1700 Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
SOUTH DAKOTA - Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING – Medicaid**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2024, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement
According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

Annual Notice Concerning Federal Laws and Acts

USA Choice Plan, USA Select Plan, and USA Consumer Plan

Benefit Year 2025

The University of South Alabama is pleased to provide its employees and their dependents with quality health and dental plans at an affordable cost to all employees.

This notice provides important information about federal laws and acts that affect your coverage. It also includes information about the policies and procedures of your Plan. You should read this notice carefully and keep it with your important papers.

This notice, along with your Summary Plan Description, will assist you in understanding your rights under the Plan and your responsibilities to the Plan.

When used in this notice, the term "Plan" refers to the USA Choice Plan, USA Select Plan and the USA Consumer Plan. The term "Member" refers to benefits-eligible employees and their dependents, unless otherwise noted. The term "Employer" refers to the University of South Alabama (USA), the USA University Hospital, the USA Children's & Women's Hospital, USA Mitchell Cancer Institute, USA Health Providence Hospital, the USA HealthCare Management, LLC (HCM), and USA Health Care Authority.

WHAT YOU SHOULD KNOW ABOUT YOUR EMPLOYER-PROVIDED HEALTH INSURANCE & HEALTH CARE REFORM

The Affordable Care Act (ACA) provides individuals with a new way to compare and purchase health insurance through the Health Insurance Marketplace. Information about the Marketplace was provided to all employees via mail in a notice titled, "New Health Insurance Marketplace Coverage Options & Your Health Coverage." You may view this notice on the benefits page of the Human Resources web site at www.southalabama. edu/hr or request a copy by contacting the USA Human Resources department.

You should understand the following important information about your employer-provided health coverage as it relates to health care reform:

1. The Plans provide "minimum essential coverage" as required by the Affordable Care Act.
2. The Plans meet the "minimum value" standard established by the Affordable Care Act. This standard is met when the health plan's share of the total allowed benefit costs covered by the plan is no less than 60% of such costs.
3. The Plans have employee cost-sharing rates which are intended to meet the "affordable" standard under the Affordable Care Act. This means that the employee cost for single coverage under the Plans is intended to be no more than 9.86% of the employee's household income (based on the employee's W-2 income).
4. The Employer offers health coverage to full-time employees working at least 20 hours of service a week or 87 hours of service a month on average.

SECTION 125 PREMIUM CONVERSION PLAN

The Section 125 Premium Conversion Plan allows you to pay your employee contribution for the USA Plans with pre-tax dollars through salary reduction rather than regular pay. The employee contribution is deducted from your paycheck before taxes are withheld. This allows you to increase your spendable income by reducing your taxes (your Social Security retirement benefit may be slightly reduced). All eligible employees are automatically enrolled in the Section 125 Premium Conversion Plan. You may change your election for pre-tax premiums during the Open Enrollment period held annually or during the Plan year if you incur a change-in-status event.

AVAILABILITY OF SUMMARY HEALTH INFORMATION

As an employee of the University of South Alabama, the health benefits available to you represent a significant component of your compensation package. These health benefits also provide important protection for you and your family in cases of illnesses or injuries. To assist you in understanding your health coverage, the USA Plans make available a Summary of Benefits and Coverage (SBC). The SBC summarizes important information about your health coverage in a standard format. The SBC and the Summary Plan Description are available on the web at: www.southalabama.edu/hr/.
A paper copy is also available, free of charge, by contacting the Human Resources department.

IMPORTANT NOTICE FOR SUMMARY PLAN DESCRIPTION

You should read the Summary Plan Description and share it with your dependents. This booklet provides valuable information about your responsibility under the Plan, eligibility, benefits, and your rights as a participant, including the right to appeal the denial of a benefit. If you do not have a copy of this booklet, you should contact the Human Resources department and one will be sent to you free of charge. The Summary Plan Description is also available online at www.southalabama. edu/departments/financialaffairs/hr/benefits.html.

PRIVACY NOTICE

The USA Plans and its associates, like Blue Cross Blue Shield of Alabama, HealthEquity, Inc., and Prime Therapeutics, adhere to and comply with the Privacy Act. The Plan and its associates have adopted practices and procedures to protect the privacy of your medical information. The Plan's privacy policy in its entirety is available from the Human Resources department and is included in your Summary Plan Description.

PATIENT PROTECTION

The Plans do not restrict coverage to any specific physician and the individual may designate any primary care, pediatrician, obstetric, gynecological, or specialty care provider in the network.

A list of covered physicians, hospitals, and other medical providers may be obtained from Blue Cross Blue Shield of Alabama and is provided at its website: www.bcbsal.org or USA Health at its web site: www.usahealth.com.

NOTICE OF THE PLAN'S OPT-OUT OF SOME FEDERAL REGULATIONS

The USA Choice Plan, USA Select Plan and USA Consumer Plan has elected to opt-out of certain federal regulations including: the Health Insurance Portability & Accountability Act of 1996 (HIPAA), as amended by the Patient Protection and Affordable Care Act (PPACA); the Newborns' and Mothers' Health Protection Act of 1996 (NMHPA); and Michelle's Law (2008). The Plans comply with the HIPAA provisions for special enrollment rules and discrimination based on health status rules.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA):

Many of the provisions of HIPAA do not apply to the Plan, or the Plan is already in compliance with these provisions. For example, HIPAA requires a special enrollment period for employees who incur a change-in-status event concerning eligibility of family members. This benefit has always been offered under the Plan. HIPAA prohibits group health plans from discriminating against employees on the basis of health status. The Plan has never imposed discriminatory rules.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT (NMHPA):

The NMHPA establishes minimum inpatient hospital stays for newborns and mothers following delivery, based on medical necessity. The Plan has never imposed limitations regarding the length of an inpatient hospital stay following delivery. The Plan's decision to opt-out of NMHPA will have no effect on current or new employees.

MICHELLE'S LAW (2008):

Michelle's Law provides that a group health plan may not terminate coverage of a full-time student due to a medically necessary leave of absence. The ACA requires coverage of a dependent to extend to age 26 regardless of full-time student status. The USA Plans comply with the ACA and extends coverage to all dependent children to age 26 regardless of student status.

NOTICE OF A SPECIAL ENROLLMENT PERIOD FOR A CHANGE-IN-STATUS EVENT

If you or any of your family members declined coverage in the Plan when first eligible for coverage (or during the annual Open Enrollment Period), you may enroll in the Plan or enroll your eligible dependents when certain events cause a change-in-status event. Some change-in-status events result in termination of coverage for a dependent. To make an enrollment change due to a change-in-status event, you must contact the Human Resources department within 30 days (unless otherwise noted) of the event. Change-in-status events include:

1. A change in your marital status (marriage, divorce, or death of your spouse).
2. A change in the number of your dependents (birth or adoption of a child, death of a child, obtaining legal custody of a child, or obtaining legal guardianship of a child by court action).
3. A change in your employment status (starting/ending employment, changing from part-time to full-time or vice versa, taking or returning from an approved leave).
4. A change in your spouse's employment status (starting/ending employment, changing from part-time to full-time or vice versa, a strike or lockout, or your spouse taking or returning from an unpaid leave or leave under the Family and Medical Leave Act or USERRA).
5. Exhaustion of your coverage period under a previous employer's COBRA continuation.
6. A significant change in the costs of or coverage provided by your spouse's employer-sponsored health plan.
7. A significant change in the costs of or coverage provided by this Plan.
8. A change in the eligibility status of a dependent child, such as the child reaching age 26, the maximum age for coverage under the Plan.
9. An end to the disability of a disabled child enrolled as your dependent under the Plan.
10. 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.
11. A required change due to a court order.
12. You or your dependent(s) becoming entitled to Medicare or Medicaid.
13. You or your dependent(s) lose coverage under Medicaid or a State Children's Health Insurance Plan (SCHIP) because of loss of eligibility. Enrollment request must be made within 60 days of the termination of coverage.
14. You or your dependent(s) become eligible for premium assistance under Medicaid or SCHIP. Enrollment request must be made within 60 days of becoming eligible for the premium assistance.

CONTACTS

Benefit	Carrier	Phone	Website
Medical & Dental	BCBS AL	877-345-6171	www.bcbsal.org
Prescription Services	Prime Therapeutics	877-345-6171	www.myprime.com
Telemedicine	Teladoc	855-477-4549	Teladoc.com/alabama
Vision	VSP	800-877-7195	www.vsp.com
Flexible Spending Account Health Savings Account	HealthEquity	866-346-5800	www.healthequity.com
Life & Disability	The Standard	800-247-6875	www.standard.com
Voluntary Benefits	Aflac	800-433-3036	www.aflacenrollment.com
Assist America	The Standard	800-872-1414 inside USA 609-986-1234 outside USA Reference# 01-AA-SUL-100101	www.assistamerica.com or email medservices@assistamerica.com
Retirement Planning	TIAA	800-842-2776	www.tiaa.org
Retirement Services	Teachers' Retirement System of Alabama	877-517-0020	www.rsa-al.gov

University Contacts

University of South Alabama Human Resources
650 Clinic Drive | TRP III, Suite 2200
Mobile, AL 36688-0002
Phone: (251) 460-6133
E-mail: employeebenefitshr@southalabama.edu

USA Health Human Resources
251 Cox Street CWEB 1 Suite 1570
Phone: (251) 415-1604
E-mail: healthhrbenefits@health.southalabama.edu

Human Resources Website
http://www.southalabama.edu/hr

NOTES

The descriptions of the benefits are not guarantees of current or future employment or benefits. If there is any conflict between this guide and the official plan documents, the official documents will govern.