



USA Health & Dental Plan – Choice Plan #78380 Coverage For: Individual + Family Plan Type: PPO

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

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$125 / individual or \$250 / family in-network \$250 / individual or \$500 / family out-of-network	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible .
Are there services covered before you meet your deductible?	Yes. Preventive services in-network are covered before you meet your deductible .	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	Yes. \$1,000 per admission deductible for out-of-network and other PPO facilities. Yes. \$100 individual/\$300 family maximum prescription drug deductible . There are no other specific deductibles .	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	For in-network \$2,250 individual / \$4,500 family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limit until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums , balance-billed charges, health care this plan doesn't cover, cost sharing for most out-of-network benefits, pre-certification penalties, specialty drug manufacturer assistance amounts for provider-administered drugs and payments made by drug manufacturer assistance programs.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Will you pay less if you use a network provider?	Yes. See AlabamaBlue.com or call 1-800-810-BLUE for a list of network providers .	This plan uses a provider network. You will pay less if you use a provider in the plan 's network. You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral .

 All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	0% coinsurance & \$15 copay	20% coinsurance	Benefits listed are USA Health Network providers ; other in-network PPO providers subject to \$40 copay and in-network overall deductible ; In, Alabama, out-of-network covered only in case of medical emergency or accidental injury; precertification is required for some provider administered drugs; if no precertification is obtained, no benefits are available
	Specialist visit	0% coinsurance & \$15 copay	20% coinsurance	
	Preventive care/screening/immunization	No Charge Deductible does not apply	Not Covered	
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	20% coinsurance	Benefits listed are USA Health Network and other PPO providers for lab and pathology and USA network for x-ray and advanced imaging; Other PPO x-ray and advanced imaging subject to \$50 copay and in-network overall deductible ; precertification may be required; if no precertification is obtained, no benefits are available; in Alabama, out-of-network covered only in case of medical emergency and accidental injury
	Imaging (CT/PET scans, MRIs)	0% coinsurance	20% coinsurance	
More information about prescription drug coverage is available at AlabamaBlue.com/pharmacy	Tier 1 Drugs (preferred generic)	\$10 copay (retail) \$10 copay (mail order)	Not Covered	Prior authorization required for specific drugs; if no precertification is obtained, no benefits are available; subject to a separate \$100 individual/\$300 family prescription drug deductible ; mail order, retail maintenance and extended supply network available for a 90 day supply subject to two copays ; the cost share for drugs on the FlexAccess Drug List may vary based on available drug manufacturer assistance; if
	Tier 2 Drugs (non-preferred generic)	\$10 copay (retail) \$10 copay (mail order)	Not Covered	
	Tier 3 Drugs (preferred brand)	\$50 copay (retail) \$50 copay (mail order)	Not Covered	

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Tier 4 Drugs (non-preferred brand)	\$75 copay (retail) \$75 copay (mail order)	Not Covered	assistance is available, the amount member pays out-of-pocket will be set by the drug manufacturer assistance program; go to AlabamaBlue.com/FlexAccessDrugList for a list of retail drugs in the FlexAccess Program; select generic specialty and biosimilar drugs on the Select Generic Specialty and Biosimilar Drugs list will have lower member cost share.
	Tier 5 Drugs (preferred specialty)	\$150 copay (retail)	Not covered	
	Tier 6 Drugs (non-preferred specialty)	50% coinsurance	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance & \$150 copay	Not covered	Benefits listed are USA Health network provider ; other in-network facilities subject to \$350 copay and in-network overall deductible ; outside Alabama, covered only in case of medical emergency or accidental injury
	Physician/surgeon fees	0% coinsurance	20% coinsurance	Benefits listed are USA Health Network and other PPO providers; in Alabama, out-of-network covered only in case of medical emergency or accidental injury; precertification may be required; if no precertification is obtained, no benefits are available
If you need immediate medical attention	Emergency room care ;	Accident: 0% coinsurance Medical Emergency: \$200 copay	Accident: 0% coinsurance Medical Emergency: \$350 copay /visit	Physician charges will apply; in-network benefits listed are USA Health Network facility; other in-network PPO facility subject to \$350 copay and in-network overall deductible for medical emergency; copay waived if admitted
	Emergency medical transportation	20% coinsurance	20% coinsurance	Subject to in-network overall deductible
	Urgent care	0% coinsurance & \$50 copay	20% coinsurance	Benefits listed are USA Health Network and other in-network PPO providers ; in Alabama, out-of-network covered only for medical emergency and accidental injury
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	\$1,000 per admission deductible & \$100 copay /day 2-5 Deductible does not apply	Benefits listed are USA Health Network providers; other in-network PPO providers subject to \$1,000 per admission deductible and \$100 copay per day for days 2-5; in Alabama, out-of-network covered for medical emergency or accidental injury only; precertification is required

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				for coverage; if no precertification is obtained, no benefits are available
	Physician/surgeon fees	0% coinsurance	20% coinsurance	Benefits listed are USA Health Network and other PPO providers; in Alabama, out-of-network covered only for medical emergency and accidental injury
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% coinsurance & \$15 copay	20% coinsurance	Benefits listed are USA Health Network providers; other in-network outpatient PPO Providers subject to \$40 copay and overall deductible ; other in-network inpatient PPO facility services \$1,000 per admission deductible & \$100 copay /day 2-5; precertification is required for intensive outpatient, partial hospitalization and inpatient hospitalization ; if no precertification is obtained, no benefits are available; in Alabama, out-of-network coverage available only for medical emergencies and accidental injury
	Inpatient services	Physician services: No Charge Deductible does not apply Inpatient Facility: 0% coinsurance	Physician services: 20% coinsurance Inpatient Facility: \$1,000 per admission deductible & \$100 copay /day 2-5 Deductible does not apply	
If you are pregnant	Office visits	0% coinsurance	20% coinsurance	Cost sharing does not apply for preventive services . Depending on the type of services, a copayment , coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound); benefits listed are USA Health Network providers; other in-network inpatient PPO facility services \$1,000 per admission deductible & \$100 copay /day 2-5; in Alabama, out-of-network coverage only available for medical emergencies and accidental injury; precertification may be required for some inpatient services; if no precertification is obtained, no benefits are available
	Childbirth/delivery professional services	0% coinsurance	20% coinsurance	
	Childbirth/delivery facility services	0% coinsurance	\$1,000 per admission deductible & \$100 copay /day 2-5 Deductible does not apply	
If you need help recovering or have	Home health care	0% coinsurance	Not Covered	Precertification is required for coverage for in-network providers outside Alabama; if no precertification is obtained, no benefits are

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
other special health needs				available; benefits are also available for home infusion services
	Rehabilitation services	0% coinsurance & \$15 copay	20% coinsurance	Benefits listed are Habilitation and Rehabilitation; each service limited to 60 visits per therapy per person per calendar year for occupational, physical and speech therapy; benefits listed are for USA Health Network; other in-network PPO providers , subject to 20% coinsurance and overall deductible
	Habilitation services	0% coinsurance & \$15 copay	20% coinsurance	Limited to a maximum of 60 days per member per calendar year; precertification is required; if no precertification is obtained, no benefits are available
	Skilled nursing care	0% coinsurance	0% coinsurance	Benefits listed are USA Health Networks and other PPO providers ; includes benefits for orthotic devices; limited to a maximum of two pair each 12 consecutive months; precertification may be required; if no precertification is obtained, no benefits are available
	Durable medical equipment	0% coinsurance	Not Covered	Limited to a lifetime maximum of 180 days per member; precertification may be required for coverage; if no precertification is obtained, no benefits are available
	Hospice services	0% coinsurance	Not Covered	
If your child needs dental or eye care	Children's eye exam	0% coinsurance & \$40 copay	Not Covered	Benefits listed are for a routine eye exam with refraction per member per calendar year; please visit AlabamaBlue.com/PreventiveServices for additional services
	Children's glasses	Not Covered	Not Covered	Not covered; member pays 100%
	Children's dental check-up	No Charge Deductible does not apply	Not Covered	Please visit AlabamaBlue.com/PreventiveServices

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

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services .)		
<ul style="list-style-type: none"> • Acupuncture • Cosmetic surgery • Dental care (See the Dental Plan) • Weight loss drugs 	<ul style="list-style-type: none"> • Hearing aids • Long-term care • Glasses, child • Experimental or Investigative procedures 	<ul style="list-style-type: none"> • Routine foot care • Custodial care • Private-duty nursing
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
<ul style="list-style-type: none"> • Bariatric surgery (Only morbid obesity in limited circumstances) • Chiropractic care (limited to 60 visits per member per calendar year) 	<ul style="list-style-type: none"> • Infertility treatment (Assisted Reproductive Technology not covered) • Non-emergency care when traveling outside the U.S. 	<ul style="list-style-type: none"> • Routine eye care (Adult) (Limitations apply) • Eye exam, child • Weight Loss Programs

Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323 x61565 or www.ccio.cms.gov or your plan administrator at the phone number listed in your benefit booklet. Other coverage options may be available to you too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information on how to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: Blue Cross and Blue Shield of Alabama at [1-800-292-8868](tel:1-800-292-8868).

Does this plan provide Minimum Essential Coverage? **Yes**

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

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

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

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

About these Coverage Examples:



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

Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)		Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)																																											
■ The plan's overall deductible	\$125	■ The plan's overall deductible	\$125	■ The plan's overall deductible	\$125																																										
■ Specialist copay	\$15	■ Specialist copay	\$15	■ Specialist copay	\$15																																										
■ Hospital (facility) coinsurance	0%	■ Hospital (facility) coinsurance	0%	■ Hospital (facility) coinsurance	0%																																										
■ Other copay/coinsurance	\$50/20%	■ Other copay/coinsurance	\$50/20%	■ Other copay/coinsurance	\$50/20%																																										
<p>This EXAMPLE event includes services like: Specialist office visits (<i>prenatal care</i>) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests (<i>ultrasounds and blood work</i>) Specialist visit (<i>anesthesia</i>)</p>		<p>This EXAMPLE event includes services like: Primary care physician office visits (<i>including disease education</i>) Diagnostic tests (<i>blood work</i>) Prescription drugs Durable medical equipment (<i>glucose meter</i>)</p>		<p>This EXAMPLE event includes services like: Emergency room care (<i>including medical supplies</i>) Diagnostic tests (<i>x-ray</i>) Durable medical equipment (<i>crutches</i>) Rehabilitation services (<i>physical therapy</i>)</p>																																											
Total Example Cost	\$12,700	Total Example Cost	\$5,600	Total Example Cost	\$2,800																																										
<p>In this example, Peg would pay:</p> <table border="1"> <thead> <tr> <th colspan="2">Cost Sharing</th> </tr> </thead> <tbody> <tr> <td>Deductibles*</td> <td>\$100</td> </tr> <tr> <td>Copayments</td> <td>\$0</td> </tr> <tr> <td>Coinsurance</td> <td>\$0</td> </tr> <tr> <th colspan="2">What isn't covered</th> </tr> <tr> <td>Limits or exclusions</td> <td>\$60</td> </tr> <tr> <td>The total Peg would pay is</td> <td>\$160</td> </tr> </tbody> </table>		Cost Sharing		Deductibles*	\$100	Copayments	\$0	Coinsurance	\$0	What isn't covered		Limits or exclusions	\$60	The total Peg would pay is	\$160	<p>In this example, Joe would pay:</p> <table border="1"> <thead> <tr> <th colspan="2">Cost Sharing</th> </tr> </thead> <tbody> <tr> <td>Deductibles*</td> <td>\$125</td> </tr> <tr> <td>Copayments</td> <td>\$600</td> </tr> <tr> <td>Coinsurance</td> <td>\$0</td> </tr> <tr> <th colspan="2">What isn't covered</th> </tr> <tr> <td>Limits or exclusions</td> <td>\$40</td> </tr> <tr> <td>The total Joe would pay is</td> <td>\$765</td> </tr> </tbody> </table>		Cost Sharing		Deductibles*	\$125	Copayments	\$600	Coinsurance	\$0	What isn't covered		Limits or exclusions	\$40	The total Joe would pay is	\$765	<p>In this example, Mia would pay:</p> <table border="1"> <thead> <tr> <th colspan="2">Cost Sharing</th> </tr> </thead> <tbody> <tr> <td>Deductibles*</td> <td>\$100</td> </tr> <tr> <td>Copayments</td> <td>\$90</td> </tr> <tr> <td>Coinsurance</td> <td>\$200</td> </tr> <tr> <th colspan="2">What isn't covered</th> </tr> <tr> <td>Limits or exclusions</td> <td>\$0</td> </tr> <tr> <td>The total Mia would pay is</td> <td>\$390</td> </tr> </tbody> </table>		Cost Sharing		Deductibles*	\$100	Copayments	\$90	Coinsurance	\$200	What isn't covered		Limits or exclusions	\$0	The total Mia would pay is	\$390
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*Note: This plan has other [deductibles](#) for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

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

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

Blue Cross and Blue Shield of Alabama:

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

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

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

Foreign Language Assistance

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

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

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

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

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

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer:

1-855-216-3144 (TTY: 711).

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

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

Gujarati: ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હોય, તો ભાષા સહાયતા સેવા, તમારા માટે નિ:શુલ્ક ઉપલબ્ધ છે. 1-855-216-3144 પર કોલ કરો (TTY: 711).

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

Hindi: ध्यान दें: अगर आपकी भाषा हिंदी है, तो आपके लिए भाषा सहायता सेवाएँ नि:शुल्क उपलब्ध हैं। 1-855-216-3144 (TTY: 711) पर कॉल करें।

Laotian: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-855-216-3144 (TTY: 711).

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

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

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

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

Italian: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-216-3144 (TTY: 711).

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-855-216-3144（TTY: 711）まで、お電話にてご連絡ください。