UNIVERSITY OF SOUTH ALABAMA

FLAGSHIP OF THE GULF COAST.

USA Choice Plan
USA Select Plan
USA Consumer Plan (HDHP)

SUMMARY PLAN DESCRIPTION SUPPLEMENT

Rev. 1/2026

USA CHOICE PLAN
USA SELECT PLAN
USA CONSUMER PLAN (HDHP)
'PLANS'

The Plans are sponsored by the University of South Alabama, USA HealthCare Management, LLC and USA Health Care Authority, collectively referred to as "Employer(s)." The Plans are governed by the Management Committee with oversight by the Fringe Benefits Committee. The Plans are offered to all eligible employees and eligible dependents when dependent coverage is elected by the employee.

The Plans are designed to comply with all required state and federal laws and acts governing the operation of an employer sponsored group health plan. The Plan are not grandfathered plans under the Affordable Care Act and comply with all requirements of that Act. The Plans are not covered by the Employee Retirement Income Security Act of 1974 commonly referred to as ERISA.

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

SELF-FUNDING BENEFITS

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

Employee eligibility is managed by the University's Human Resources Department and the University contracts with the Claim Administrator, **Blue Cross Blue Shield of Alabama** for medical and dental benefits and **Prime Therapeutics, Inc** for pharmacy benefits, to process claims and pay benefits.

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

SUMMARY PLAN DESCRIPTION SUPPLEMENT

This Summary Plan Description (SPD) Supplement has been prepared in an easy-to-read format to assist you with understanding the Plan and is a supplement to the applicable Plan SPD. It describes the benefits available under the Plan.

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

Limitations and exclusions apply to some medical conditions and services. Some of the exclusions, limitations and provisions are described in the SPD. See the applicable SPD for details.

ADMINISTRATION: There is one claims administrator for Medical, Pharmacy and Dental benefits. You will be issued one identification card covering all benefits. Your identification card will include information for providers on the medical, pharmacy and dental benefits.

USA HEALTH NETWORK OF PROVIDERS

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

Effective January 1, 2026, there will be changes in the classification of certain providers that have been considered in-network for purposes of coverage in the USA health plans. Most providers who are not employed by USA Health will be classified as BCBS Alabama PPO providers. Copays and other out-of-pocket expenses are based on the provider network where the provider is assigned. In calendar year 2026, copays and other out-of-pocket expenses may be different than what a patient paid in previous years due to the reclassification. More details related to copays and out-of-pocket expenses for each provider networks are available in the Plan Matrix for each plan, at SouthAlabama.edu/jagsopenenrollment. To search for USA Health providers, please visit: usahealthsystem.com. To search for BCBS of Alabama PPO providers, please use the Find a Doctor link at bcbsal.org.

PHYSICIAN REFERRAL LINE

USA Health – (251) 434-3711

USA University Hospital
USA Providence Hospital
USA Children's & Women's Hospital
USA Mitchell Cancer Institute
USA Strada Patient Care Center
USA Mobile Diagnostic Center
USA Physicians Group
USA Mastin Patient Care Center
USA College of Medicine

This is only a partial listing of the USA Health providers. Visit the USA Health website for more details: usahealthsystem.com

ELIGIBILITY FOR THE PLAN

The USA Choice Plan, USA Select Plan and USA Consumer Plan (HDHP) applies to employees of the University of South Alabama, USA Health Care Management, and USA Health Care Authority, commonly referred to as the Employer(s). Employees who are in a benefits-eligible position based on the Plan Eligibility Policy are offered this coverage and may elect to cover Eligible Dependents. The employee must also elect single or family coverage authorizing payment of the required monthly cost sharing amount.

The Plan Eligibility Policy is intended to comply with the Affordable Care Act which requires an offer of coverage to all employees credited with 30 hours of service per week or 130 hours of service per month on average. However, eligible employees include the following:

1) An employee with a specific appointment with no termination date, occupying a permanently budgeted position, and working a minimum of 20 hours per week on a regular basis.
2) All employees, regardless of the employment start date (first date of active employment), that are credited with 20 hours of service per week or 87 hours of service per month on average.

Coverage may start the later of the first of the month following the employee's start date or the first of the month following the date the application for coverage is received by the Human Resources Department.

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

ELIGIBLE DEPENDENTS

Eligible Dependents include:

1. Spouse.
2. Child up to age 26 (married or unmarried).
3. Your unmarried disabled child of any age provided the disability commenced prior to age 26, is mentally or physically disabled or incapacitated, is incapable of self-sustaining employment, and is dependent upon the employee for support and lives with the employee in a regular parent-child relationship. Coverage under the Plan continues without interruption for the duration of the disability so long as the employee maintains dependent coverage.

The term Child may include the following when Required Documents are filed:

1. Natural-born or legally adopted child, including a legally adopted child living with you as the adopting parent during a period of probation from an authorized placement agency or by judgment, decree or other order of any competent jurisdiction.
2. Stepchild.
3. Child who permanently resides in your home and over whom you have legal guardian status by court appointment.
4. Child for whom you are legally required to provide health insurance coverage during the period specified in a Qualified Medical Child Support Order (QMCSO).

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

RESPONSIBILITIES TO THE PLAN

Employees and Eligible Dependents have obligations to the Plans. These responsibilities are designed to ensure all benefits and eligibility rules are applied equally and fairly to all Members. It is important that you fulfill your responsibility in part by reading the applicable Plan SPD and this SPD Supplement. It will explain your rights to benefits and your obligations to the Plan.

EMPLOYEE RESPONSIBILITIES

1. Each Employee is responsible for providing to the Human Resources Department and the Claims Administrator the information necessary for the purpose of administering the Plan. Payment of benefits is conditioned upon the Plan promptly receiving the complete information necessary to provide benefits.
2. The Employee is responsible for applying for coverage in the electronic benefits platform as instructed by Human Resources. A Qualifying Life Event must also be submitted electronically to add or remove dependents. Addition or removal of dependents is not done automatically, and can be accomplished only through proper completion and acceptance of the completed request electronically by the Human Resources Department.
3. Electronic enrollment must be completed within 30 days of employment or within 30 days of a Qualifying Life Event.
4. Additional information requested by the Human Resources Department must be provided in writing within 30 days.
5. The Employee is responsible for notifying the Human Resources Department of any Qualifying Life Event. Failure to report an event causing the dependent to no longer qualify as an Eligible Dependent will result in the Employee becoming liable for benefits paid by the Plan on behalf of that individual. Example, a divorced spouse has coverage terminate the last day of the month in which the divorce is finalized. An Employee who fails to notify the Human Resources Department of a divorce will be responsible for reimbursing the University for benefits paid on behalf of the divorced spouse incurred after the date of divorce.

   Additionally, employees have **30 days** from the child's date of birth or adoption to add the child to their medical plan. Failure to complete the necessary steps within this timeframe will result in the child not being added to coverage, and no exceptions will be made after the 30-day window has passed.

MEMBER RESPONSIBILITIES

Each Member is responsible for adhering to the following requirements:

1. Carefully reading the applicable Plan SPD and this SPD Supplement to ensure an understanding of the Plan's eligibility rules, benefits, provisions and limitations.
2. Checking with the medical provider prior to receiving any services to verify the provider is a Network Provider and medical services are Covered Services.
3. Following requirements for Precertification.
4. Filing a claim, if required, within 12 months of the date of service. Refer to the section titled How to File a Claim.
5. Assisting the Claims Administrator with coordination of benefits, the Plan's right of subrogation, right of reimbursement and right of recovery of payments made in error. Payment of benefits is conditioned upon the Plan promptly receiving the complete information necessary to provide benefits.
6. Timely notification to the Human Resources Department when a Member ceases to be an Eligible Dependent or becomes eligible for Medicare.

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

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

REQUIRED DOCUMENTATION

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

See the table of **Required Documentation** for acceptable dependent eligibility documentation.

Required Documentation For Dependents

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 member and spouse. ▪ Current property tax documents listing both member and spouse. ▪ Vehicle registration currently in effect listing both member and spouse. ▪ Current credit card or bank account statement listing both member and spouse. ▪ Current utility bill listing member and spouse. Note: "Current" is defined as within the last six months.
Separated spouse	▪ Court document signed by judge showing legal separation.
Common law spouse – NOT ELIGIBLE ON AND AFTER 1/1/2017	**Common law spouse status prior to 1/1/2017 – Each of the following**: ▪ Questionnaire and affidavits provided by Human Resources Department. ▪ Most recent federal income tax return as filed with the IRS listing the spouse. ▪ One of the documents listed in the spouse category above as proof of current marriage 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 member and spouse. ▪ Birth certificate issued by state, county or vital records office showing spouse as parent. **Note: If spouse is not covered by the Plan, you will need to provide proof that you and your spouse are currently married.**
Adopted child under age 26	**One of the following documents:** ▪ Certificate 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 the dependent of member since the disability commenced.
Grandchild	A grandchild may only be covered if legally adopted and living in the employee's home.

Pursuant to recent federal health care reform, a child under the age of 26 can be married and there are no conditions of residency, student status, or financial dependency.

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

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

BEGINNING OF COVERAGE

Enrollment requires completion of an election in electronic online benefits enrollment platform.

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

If you fail to complete an online benefits enrollment election within 30 days of your first day of employment, you must wait until the Open Enrollment Period to apply for coverage beginning the first of the following calendar year.

Eligible Dependents will be covered on the date you become covered, assuming you have an online enrollment election for Dependent Coverage that has been accepted by the Human Resources Department. If you enroll during the Open Enrollment Period, held annually, coverage will begin on January 1st of the following calendar year. Dependent Coverage may also be added during the Open Enrollment Period, to be effective on the first day of the following calendar year.

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

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

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

WHEN COVERAGE TERMINATES

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

1. The first day of the month following the month in which you cease to be an Employee, or your employment status changes so that you are no longer in a benefits-eligible status.
2. The first day of the month for which you fail to make payment of the Employee Contribution.
3. The first day of the month for which a Member fails to make timely payment of the required COBRA premium.
4. The day you enter full-time military service, except as provided by USERRA, as explained in the applicable Plan SPD.
5. Upon discovery of fraud or misrepresentation of a material fact.
6. The day the Plan is terminated or coverage for a class of Members is terminated.

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

1. The day the Employee's coverage terminates.
2. The first day of the month following the date the individual no longer meets the definition of an Eligible Dependent, which includes the:
   a) Date of divorce.
   b) Date your child attains age 26.
3. The first day of the month for which you fail to make payment of the Employee Contribution for Dependent Coverage.
4. When you fail to provide information to verify dependent status within 30 days of receipt of a request for verification from the Human Resources Department or Claims Administrator; in such case, coverage terminates retroactive to the earliest date it is determined the individual ceased to be an Eligible Dependent.

A dependent that loses coverage under the Plan is eligible for COBRA continuation of coverage only if the Human Resources Department is notified in writing within 60 days of the event that caused the individual to no longer meet the definition of an Eligible Dependent. Coverage will terminate retroactively to the first of the month following the event.

If coverage for a spouse is terminated due to divorce, and an Eligible Employee is required by the terms of the divorce judgment to provide health insurance coverage for the divorced spouse, coverage may be provided under this Plan only through COBRA continuation of coverage. The divorced spouse is no longer an Eligible Dependent under this Plan and may continue coverage only through COBRA. If notice to the Human Resources Department is not made within 60 days of the date of divorce, COBRA continuation of coverage will not be available to the divorced spouse.

OPEN ENROLLMENT PERIOD

There is an Open Enrollment Period held annually with dates announced in advance, which an Employee may enroll in the USA Choice Plan, USA Select Plan, USA Consumer Plan (HDHP) and/or add Eligible Dependents. During this period, you will complete your enrollment online in Employee Navigator and coverage will begin on the first day of the following calendar year, if all eligibility requirements, including providing dependent document, have been met.

SPECIAL ENROLLMENT PERIOD DUE TO QUALIFYING LIFE EVENTS

You may also enroll in the Plan, enroll your Eligible Dependents or terminate coverage for yourself or a dependent when certain events cause a Qualifying Life Event. To make an enrollment change due to a Qualifying Life Event, **you must complete your online election in Employee Navigator within 30 days (unless otherwise noted) of the event.**

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

1. A change in your marital status (marriage, divorce, legal separation or death of the spouse).
2. A change in the number of your dependents (birth or adoption of a child, death of a child, obtaining legal guardianship).
3. A change in your, or your spouse's, employment status (starting/ending employment, changing from part-time to full-time or vice versa, a strike or lock-out, or taking or returning from an unpaid leave of absence or leave under the Family and Medical Leave Act or USERRA during which your, or your spouse's, coverage terminated).

4. Exhaustion of your coverage period under a previous employer's COBRA continuation.
5. A significant change in the cost of or coverage provided by your spouse's employer-sponsored health plan, or a significant change in the cost of or coverage provided by this Plan.
6. A change in the eligibility status of a dependent child (child reaching the maximum age for coverage under the Plan).
7. An end to the Disability of a Disabled child enrolled as your dependent under the Plan.
8. A change in your residence or work site, or that of a spouse or dependent, which affects ability to access benefits under this or another employer-sponsored health plan.
9. A change required by a court order.
10. You or your dependent becoming entitled to Medicare or Medicaid.
11. You or your dependent(s) loss of coverage under Medicaid or a State Children's Health Insurance Plan (SCHIP) because of loss of eligibility. An enrollment request must be made within 60 days of the termination of coverage.
12. You or your dependent(s) becomes eligible for the premium assistance under Medicaid or SCHIP. An enrollment request must be made within 60 days of becoming eligible for the premium assistance.

The change in coverage must be consistent with the Qualifying Life Event, and you must provide written documentation, upon request, to verify the Qualifying Life Event.

DUPLICATE COVERAGE EXCLUDED

If both you and your spouse are eligible for the Plans as Employees:

1. Both Employees may elect single coverage.
2. One Employee may elect Dependent Coverage and the spouse may be covered as an Eligible Dependent. Under no circumstances may both Employees elect Dependent Coverage or an Employee be covered as both an Eligible Employee and Eligible Dependent.

CONTINUATION WHILE ON APPROVED LEAVE

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

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

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

SURVIVING DEPENDENT BENEFIT

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

The monthly premium required for coverage is the funding rate with no Employer Contribution.
This benefit is available only if the surviving dependents are not eligible for enrollment in any other group health plan, including that provided by a surviving dependent's employer, or Medicare.

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

Coverage may be continued until the earlier of:

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

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

LEGAL PROTECTION FOR CONTINUATION OF COVERAGE

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

RESCISSION OF COVERAGE

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

ELIGIBILITY & SECONDARY REVIEW

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

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

All information must be submitted in writing to:

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

Your request for review will be considered by the USA Management Committee and you will receive a written response within 60 days.

THE PLAN'S OPT-OUT OF SOME FEDERAL REGULATIONS

The Plan has elected to opt-out of certain federal regulations including: The Health Insurance Portability & Accountability Act of 1996 (HIPAA), as amended by the Affordable Care Act; the Newborns' & Mothers' Health Protection Act of 1996 (NMHPA); and Michelle's Law (2008). You can find additional information about the opt-out including a notice specific to that action and the effect it may have on your coverage in the Annual Federal Notice located within the Benefits Guide. You and your physician or medical provider ultimately decide on the medical treatment that best manages your medical condition and this may include medical care that is not covered by the Plan. You and your physician should work with the Claims Administrator to determine coverage for your specific treatment.

The Plan does comply with the HIPAA provisions for special enrollment rules and the discrimination based on health status rules.

USA Health & PPO Providers

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

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

The keystone of the Plan is to incent utilization of USA Health providers where the cost is lower. This arrangement acknowledges that not all medical services are offered through USA Health providers. Where those services are not offered the benefit will be less. In fact, if it were not for USA Health providers, all benefits would be reduced. The use of a non-USA Health provider means that there is no available savings to be shared.

Newborns' & Mothers' Health Protection Act:

Federal law prohibits restricting benefits for a hospital length of stay for childbirth for the mother or newborn child to less than 48 hours following vaginal delivery or less than 96 hours following a Cesarean section. An earlier discharge is permitted after consultation with the mother and physician.

PREVENTIVE CARE SERVICES

The Plan provides preventive care services covered at 100%, with no deductible or copay, but only when received by a USA Health provider. You can find a listing of all preventive care services covered by the Plan at –

www.AlabamaBlue.com/preventiveservices

You can contact the Human Resources Department for a listing

TELEPHONE & ONLINE VIDEO CONSULTATIONS

TELADOC – 1-855-477-4549

USA Select provides 100% coverage for telephone and online video consultations.

A Teladoc visit can diagnose, treat, and prescribe medication for certain general medical issues like flu, allergies, sinus infection, sore throat, and other minor health issues.

ANNUAL FEDERAL NOTICES

The required annual benefit notices, including HIPAA, COBRA, CHIPRA, and more are available digitally for easy access. To view or download your copy, simply scan the QR code with your mobile device. These documents contain important information about your rights and coverage.

A copy of the notice may also be obtained from –

University of South Alabama
Human Resources Department
Technology & Research Park
650 Clinic Drive
Building 3, Suite 2200
Mobile, AL 36688
(251) 460-6133

BE AS HEALTHY AS YOU CAN BE WITH myBlueCross —

Blue Cross Blue Shield wants you to be as healthy as you can be. That is why BCBS created the myBlueCross – an online service only for members. Use it to easily manage your healthcare coverage. All you have to do is register at AlabamaBlue.com/Register. You will have 24-hour access to personalized healthcare information, PLUS easy-to-use online tools that can help you save time and efficiently manage your healthcare including:

▲ Access to the Member Handbook.
▲ Track your health progress.
▲ Order replacement ID cards.
▲ Take a health assessment quiz.
▲ View claim reports.
▲ Get prescription drug information.
▲ Find a doctor.
▲ Get fitness, nutrition, and wellness tips.

You also have access to a BlueCare Health Advocate who serves as a personal coach and advisor. Your BlueCare Health Advocate can explain your benefits, help you to locate a doctor or specialist and help you make an appointment, research, and resolve hospital and doctor billing issues, assist you in finding support groups and community services available to you. To find out more or to contact your BlueCare Health Advocate, call our Customer Service Department at the number on the back of your ID card.

PRIMARY CARE PHYSICIAN

You are not required to have a primary care physician and no referral is required to see a specialty physician, but having a primary care physician will greatly improve your health.

Having a primary care physician has many benefits, including:

- Seeing a physician who knows you and understands your medical history.
- Having someone you can count on as a key resource for your healthcare questions.
- Help when you need to coordinate care with specialist and other providers.
- Seeing your primary care physician for an annual checkup can result in early detection of disease when treatment will be more effective.

Typically, primary care physicians specialize in family medicine, internal medicine or pediatrics.

RETIREE HEALTH PLAN

Public Education Employees Health Insurance Plan (PEEHIP)

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

http://www.rsa-al.gov/index.php/members/peehip/pubs-forms/

Your Employer makes a significant contribution towards the cost of your PEEHIP Health coverage after your retirement under the Teachers' Retirement System if you elect to continue coverage.

USA Health Care Management and USA Health Care Authority do not participate in the retiree extended coverage and coverage terminates for these employees at termination of employment with the COBRA privilege.