

Effective Dates: January 1, 2020 – December 31, 2020

## Attachment A to Certificate of Coverage

The Plan's services and benefits, with their copayments, coinsurance, and some of the limitations, are listed below. Please remember that this is only a brief listing. For further information, plan guidelines, and exclusions, please see the Certificate of Coverage.

Please keep this Attachment A for your records.

MEDICAL BENEFITS	COVERAGE UAB Network	COVERAGE VIVA HEALTH Network (outside UAB)
<b>CALENDAR YEAR OUT-OF-POCKET MAXIMUM:</b> The most a Member will pay per Calendar Year for qualified medical, mental, and substance abuse services, prescription drugs, and specialty drugs. The maximum includes deductibles, copayments, and coinsurance paid by the Member for qualified services but does not include premiums or out-of-network charges over the maximum payment allowance. See the Certificate of Coverage for details.		\$6,600 per individual; \$13,200 per family
<b>PREVENTIVE CARE:</b> <ul style="list-style-type: none"> <li>Well Baby Care (Children under age 3)</li> <li>Routine Physicals (One per Calendar Year for ages 3+)</li> <li>Covered Immunizations</li> <li>Preventive Prenatal Care (As defined in the Certificate of Coverage)</li> <li>OB/GYN Preventive Visit (One per Calendar Year)</li> <li>Other preventive items and services. See Certificate of Coverage for recommendations and guidelines.</li> </ul>	100% Coverage	100% Coverage
<b>OTHER PRIMARY CARE SERVICES:</b> <ul style="list-style-type: none"> <li>Medical Physician Services</li> <li>Illness and Injury</li> <li>Hearing Exams</li> <li>X-Ray and Laboratory Procedures <ul style="list-style-type: none"> <li>Covered Genetic Testing</li> </ul> </li> </ul>	\$15 Copayment per visit  80% Coverage	\$20 Copayment per visit  80% Coverage
<b>SPECIALTY CARE:</b> (No PCP Referral Required) <ul style="list-style-type: none"> <li>Medical Physician Services</li> <li>Illness and Injury</li> <li>OB/GYN Services</li> <li>X-Ray and Laboratory Procedures <ul style="list-style-type: none"> <li>Covered Genetic Testing</li> </ul> </li> </ul>	\$30 Copayment per visit  80% Coverage	\$40 Copayment per visit  80% Coverage
<b>URGENT CARE CENTER SERVICES:</b> <ul style="list-style-type: none"> <li>Medical Physician Services</li> <li>Illness and Injury</li> </ul>	\$15 Copayment per visit at UAB Urgent Care; \$30 Copayment per visit at all other urgent care centers	\$40 Copayment per visit
<b>VISION CARE:</b> (No PCP Referral Required) <ul style="list-style-type: none"> <li>One routine vision exam per Calendar Year</li> <li>Other eye care office visits</li> </ul>	\$30 Copayment per visit \$30 Copayment per visit	\$30 Copayment per visit \$30 Copayment per visit
<b>ALLERGY SERVICES:</b> (No PCP Referral Required) <ul style="list-style-type: none"> <li>Physician Services</li> <li>Testing</li> </ul>	\$30 Copayment per visit 80% Coverage	\$40 Copayment per visit 80% Coverage
<b>DIAGNOSTIC SERVICES:</b> (Including but not limited to CT Scan, MRI, PET/SPECT, ERCP)	\$100 Copayment per service	\$200 Copayment per service
<b>OUTPATIENT SERVICES:</b> <ul style="list-style-type: none"> <li>Surgery and Other Outpatient Services</li> </ul>	\$150 Copayment per visit	\$250 Copayment per visit
<b>HOSPITAL INPATIENT SERVICES:</b> <ul style="list-style-type: none"> <li>Physician Services</li> <li>Semi-Private Room</li> </ul>	100% Coverage \$250 Copayment per admission	100% Coverage \$250 Copayment per day (Days 1-5)
<b>MATERNITY SERVICES:</b> (Covered for employee and employee's spouse; not covered for dependent children except as provided under Preventive Care.) <ul style="list-style-type: none"> <li>Physician Services (Prenatal, delivery, and postnatal care)</li> <li>Maternity Hospitalization</li> </ul> Eligible baby must be enrolled in plan within 30 days of birth or adoption for baby's care to be covered.	\$30 Copayment per delivery \$250 Copayment per admission	\$40 Copayment per delivery \$250 Copayment per day (Days 1-5)
<b>EMERGENCY ROOM SERVICES:</b>	\$100 Copayment per visit (waived if admitted within 24 hours)	\$200 Copayment per visit (waived if admitted within 24 hours)
<b>EMERGENCY AMBULANCE SERVICES:</b> (Must be Medically Necessary)	80% Coverage	80% Coverage
<b>DURABLE MEDICAL EQUIPMENT AND PROSTHETIC DEVICES:</b>	80% Coverage	80% Coverage
<b>SKILLED NURSING FACILITY SERVICES:</b> (Limited to 60 days per Calendar Year)	80% Coverage	80% Coverage
<b>DIABETES SELF-MANAGEMENT EDUCATION:</b>	\$30 Copayment per visit	\$40 Copayment per visit
<b>DIABETIC SUPPLIES:</b> Insulin covered under prescription drug rider. For Diabetic Supplies call VIVA HEALTH.	100% Coverage	100% Coverage
<b>REHABILITATION SERVICES:</b> Physical, Speech, and Occupational Therapy	\$30 Copayment per visit; \$250 Copayment per admission	\$40 Copayment per visit; \$250 Copayment per day (Days 1-5)
<b>HABILITATION SERVICES:</b> Physical, Speech, and Occupational Therapy and Applied Behavior Analysis (limited to a diagnosis of Autism, Autism Spectrum Disorder, or Pervasive Developmental Delay)	\$30 Copayment per visit	\$40 Copayment per visit

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MEDICAL BENEFITS	COVERAGE UAB Network	COVERAGE VIVA HEALTH Network (outside UAB)
<b>CHIROPRACTIC SERVICES:</b> (No PCP Referral Required)	\$40 Copayment per visit	
<b>HOME HEALTH CARE SERVICES:</b> (Limited to 60 visits per Calendar Year)	80% Coverage	80% Coverage
<b>TEMPOROMANDIBULAR JOINT DISORDER:</b>	\$30 Copayment per visit	\$40 Copayment per visit
<b>SLEEP DISORDERS:</b> Sleep Study	\$30 Copayment per visit; \$150 Copayment per sleep study	\$40 Copayment per visit; \$250 Copayment per sleep study
<b>TRANSPLANT SERVICES:</b>	100% Coverage after \$250 Hospital Copayment	100% Coverage after \$250 Copayment per day (Days 1-5)
<b>MENTAL HEALTH &amp; SUBSTANCE ABUSE SERVICES<sup>1</sup>:</b> <ul style="list-style-type: none"> <li>Inpatient Services</li> <li>Outpatient Services</li> </ul> <sup>1</sup> Residential treatment and certain diagnoses are excluded. See your Certificate of Coverage for details.	100% Coverage after \$250 Copayment per admission \$30 Copayment per visit	100% Coverage after \$250 Copayment per day (Days 1-5) \$40 Copayment per visit
<b>PHARMACY DEDUCTIBLE:</b> Applies to all drugs except for generic oral contraceptives and other preventive drugs required by the Affordable Care Act.	\$100 per individual; \$200 aggregate amount per family	
PHARMACEUTICAL BENEFITS	COVERAGE	
<b>COVERED PRESCRIPTION DRUGS<sup>2</sup>:</b> <ul style="list-style-type: none"> <li><b>Generic Drugs</b> <ul style="list-style-type: none"> <li>From a Participating Pharmacy: \$15 Copayment per 31-day supply</li> <li>Mail-order: \$30 Copayment per 90-day supply</li> <li>Participating Pharmacy: \$45 Copayment per 90-day supply</li> </ul> </li> <li><b>Preferred Brand Drugs</b> <ul style="list-style-type: none"> <li>From a Participating Pharmacy: \$35 Copayment per 31-day supply</li> <li>Mail-order: \$88 Copayment per 90-day supply</li> <li>Participating Pharmacy: \$105 Copayment per 90-day supply</li> </ul> </li> <li><b>Non-Preferred Brand Drugs</b> <ul style="list-style-type: none"> <li>From a Participating Pharmacy: \$60 Copayment per 31-day supply</li> <li>Mail-order: \$150 Copayment per 90-day supply</li> <li>Participating Pharmacy: \$180 Copayment per 90-day supply</li> </ul> </li> <li><b>Oral Contraceptives</b>: \$0 Copayment for generic drugs; Applicable Copayment for brand drugs</li> <li><b>Biological Drugs, Biotechnical Drugs, and Specialty Pharmaceuticals<sup>3</sup></b>: 80% Coverage</li> <li><b>Diabetic Testing Supplies</b>: 100% Coverage</li> </ul>		
<sup>2</sup> Some medications may require prior authorization from VIVA HEALTH. For further information, please contact Customer Service at the phone number listed below. <sup>3</sup> May be administered in the home, physician's office or on an outpatient basis. When these medications are received from Express Scripts, they must be ordered by calling 1-800-803-2523. For a list of medications in this category, please refer to <a href="http://www.vivaemployer.com/Members/Default.aspx">http://www.vivaemployer.com/Members/Default.aspx</a> . <b>When generic is available, Member pays difference between generic and Brand price, plus Copayment.</b> <b>Check with your participating pharmacy to learn if it is eligible to offer a 90-day supply at retail.</b>		
<b>SMOKING CESSATION PRODUCTS:</b> Two, 12-week treatment courses total per Calendar Year. Prescription required. [Generic nicotine replacement products (including the patch, lozenge, gum, inhaler, or nasal spray), or Nicotrol (inhaler), or Nicotrol NS (nasal spray), or Generic Zyban, or Varenicline tartrate (Chantix).]	\$0 Copayment	
<b>DEPENDENT STUDENT BENEFITS:</b> (Emergencies and in-area care are covered under the appropriate sections set forth in the Certificate of Coverage.)	Services to treat an illness or injury for Covered Dependents will be covered while they are full-time students at an accredited educational institution out of the Service Area, subject to the Copayments described herein and a \$1,500 maximum benefit per Calendar Year.	
<b>SABBATICAL:</b> (Sabbatical leave is a period of paid leave granted to faculty members by the Employer to pursue professional development, a program of investigation, creative writing, or artistry, and the like.)	Services to treat an illness or injury for Subscribers and Covered Dependents on Sabbatical Leave will be covered while they are out of the Service Area, subject to the Copayments described herein and a \$1,500 maximum benefit per Calendar Year.	

**VIVA HEALTH Customer Service: (205) 558-7474 or 1-800-294-7780 | Visit our Website at [www.vivahealth.com](http://www.vivahealth.com)**

- Eligible Dependent:** To be eligible to enroll as a Covered Dependent, a person must be listed on the enrollment application completed by the Subscriber, reside in the Service Area or with the Subscriber (exceptions apply), and meet additional qualifying criteria. For exceptions and additional qualifying criteria, please refer to the Certificate of Coverage.
- Pre-Existing Condition Policy:** No pre-existing condition exclusions or waiting period.
- Nondiscrimination Notice:** VIVA HEALTH complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.
- Language Assistance Services:** ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-294-7780 (TTY: 711).  
 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 1-800-294-7780 (TTY : 711)。

The UAB network includes all pediatric care for dependents under age 18 regardless of whether those dependents receive their pediatric care in the VIVA HEALTH network or the UAB network. The VIVA HEALTH network includes hospitals and health centers contracted with VIVA HEALTH but outside of UAB. UAB means University Hospital, UAB Women and Infants Center, UAB Highlands, The Kirklin Clinic, Medical West, UAB Callahan Eye Hospital, Spain Rehabilitation Center, and all UAB satellite clinics.