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, visit https://www.vivahealth.com/Group/Login/. 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.healthcare.gov/sbc-glossary or call 1-800-294-7780 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$500/individual or $1,500/family	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. If you participate in your employer's HRA, the HRA will pay for or reimburse you for certain qualified medical expenses (including deductibles and coinsurance) up to the balance available in your HRA. Your HRA has an overall contribution limit of $150/plan year for single coverage, $300/plan year for single plus children coverage and single plus spouse coverage, and $450/plan year for family coverage. You are responsible for all expenses the balance available in your HRA.
Are there services covered before you meet your deductible?	Yes. Preventive care, most drugs, and benefits with a copayment.	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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$7,350/individual or $14,700/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 limits 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, and out-of-network expenses for non-emergency and non-urgent services.	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 myvivaprovider.com or call 1-800-294-7780 for a list of network providers.	This plan uses a provider network. You pay the least if you use a provider in the UAB provider network. You pay more if you use a provider outside the UAB provider 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	$35 copay/visit	Not covered	Deductible does not apply. Teladoc telehealth Primary/Urgent Care service: $0/consultation.
	Specialist visit	$50 copay/visit	Not covered	Deductible does not apply. Chiropractic services limited to 25 visits per calendar year. Teladoc telehealth Behavioral Health service: $50/consultation. Medical Nutritionist counseling limited to 6 visits per Calendar Year with a Nutritionist or Registered Dietitian.
	Preventive care/screening/ immunization	No charge	Not covered	Limited to services recommended by federal preventive guidelines. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. Deductible does not apply.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance for lab work; $10 copay/image for x-rays	Not covered	Office visit or facility copay may also apply. Covered genetic testing subject to 20% coinsurance. Genetic testing requires prior authorization. If prior authorization is not obtained, no charges for those services will be covered by the plan. Deductible does not apply to x-ray imaging.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	Not covered	Certain imaging tests require prior authorization for plan to pay for them. See plan documents for more information. If prior authorization is not obtained, no charges for those services will be covered by the plan.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.vivahealth.com	Tier 1 Drugs (preferred generic drugs)	$10 copay/prescription (retail); $25 copay/ prescription (mail order)	Not covered	Covers up to a 30-day supply (retail); 90-day supply (mail order). No charge for generic oral contraceptive drugs. Deductible does not apply.
	Tier 2 Drugs (non-preferred generic drugs)	$30 copay/prescription (retail); $75 copay/ prescription (mail order)	Not covered	Covers up to a 30-day supply (retail); 90-day supply (mail order). No charge for generic oral contraceptive drugs. Deductible does not apply.
	Tier 3 Drugs (preferred brand and	$75 copay/prescription (retail); $187 copay/	Not covered	Covers up to a 30-day supply (retail); 90-day supply (mail order). If generic is available, you pay the difference between the generic

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)	
	non-preferred generic drugs)	prescription (mail order)		and brand price, plus the copay. Deductible does not apply. No charge for generic and select brand oral contraceptive drugs.
	Tier 4 Drugs (non-preferred brand and non-preferred generic drugs)	$100 copay/prescription (retail); $250copay/ prescription (mail order)	Not covered	Covers up to a 30-day supply (retail); 90-day supply (mail order). If generic is available, you pay the difference between the generic and brand price, plus the copay. Deductible does not apply. No charge for generic and select brand oral contraceptive drugs.
	Tier 5 Drugs (specialty drugs and non-preferred drugs)	30% coinsurance	Not covered	Requires prior authorization for plan to pay for drugs. Call 1-800-803-2523. If prior authorization is not obtained, no charges for those services will be covered by the plan. Deductible applies to drugs received directly from a physician or hospital.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$300 copay/service at UAB; 10% coinsurance (hospital services outside UAB); $250 copay/service (services at an ambulatory surgery center)	Not covered	Requires prior authorization for plan to pay for outpatient surgery. If prior authorization is not obtained, no charges for those services will be covered by the plan. Deductible does not apply to outpatient services performed at UAB or at an Ambulatory Surgical Center.
	Physician/surgeon fees	10% coinsurance (hospital services outside UAB); no charge for services performed at an ambulatory surgical center or at UAB	Not covered	Requires prior authorization for plan to pay for outpatient surgery. If prior authorization is not obtained, no charges for those services will be covered by the plan. Deductible does not apply to outpatient services performed at UAB or at an Ambulatory Surgical Center.
If you need immediate medical attention	Emergency room care	$275 copay/visit at UAB; $325 copay/visit outside UAB	$275 copay/visit	Limited to emergency medical conditions. Follow-up care is not covered. See plan documents for more information. Deductible does not apply.
	Emergency medical transportation	10% coinsurance	10% coinsurance	Limited to transportation to a hospital.
	Urgent care	$35 copay/visit (primary care); $50 copay/visit (urgent care center)	$50 copay/visit	Coverage from non-participating providers is limited to care outside the VIVA HEATH service area and requires prior authorization or a referral from a participating provider. If prior authorization or a referral is not obtained, no charges for those services will be covered by the plan. Deductible does not apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 copay/day (Days 1-5) at UAB; 10% coinsurance/	Not covered except for emergency	Requires prior authorization for plan to pay for admission except for emergency medical conditions. If prior authorization is not

* For more information about limitations and exceptions, see the plan or policy document at https://www.vivahealth.com/Group/Login/

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)	
		admission outside UAB	medical conditions	obtained, no charges for those services will be covered by the plan. Deductible does not apply to services performed at UAB.
	Physician/surgeon fees	No charge at UAB; 10% coinsurance/admission outside UAB	Not covered except for emergency medical conditions	Requires prior authorization for plan to pay for admission except for emergency medical conditions. If prior authorization is not obtained, no charges for those services will be covered by the plan. Deductible does not apply to services performed at UAB.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$50 copay/visit	Not covered	Partial Hospitalization & Intensive Outpatient Program services require prior authorization for plan to pay for admission. If prior authorization is not obtained, no charges for those services will be covered by the plan. Deductible does not apply.
	Inpatient services	$250 copay/day (Days 1-5)	Not covered except for emergency medical conditions	Requires prior authorization for plan to pay for admission. If prior authorization is not obtained, no charges for those services will be covered by the plan. Deductible does not apply.
If you are pregnant	Office visits	$50 copay/delivery	Not covered	No coverage for dependent children except for preventive prenatal care. See plan documents for more information. No coverage for surrogate pregnancy. Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC. Deductible does not apply to services performed at UAB.
	Childbirth/delivery professional services	No Charge at UAB; 10% coinsurance/admission outside UAB	Not covered	
	Childbirth/delivery facility services	$250 copay/day (Days 1-5) at UAB; 10% coinsurance/ admission outside UAB	Not covered	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	Not covered	Requires prior authorization for plan to pay for care. Limited to 60 visits per calendar year. If prior authorization is not obtained, no charges for those services will be covered by the plan.
	Rehabilitation services	10% coinsurance	Not covered	Requires prior authorization for plan to pay for therapy. If prior authorization is not obtained, no charges for those services will be covered by the plan. Limited to 30 total outpatient visits per calendar year for physical, occupational, and speech therapy for rehabilitation and habilitation services combined and 60 inpatient days for rehabilitation.
	Habilitation services	10% coinsurance	Not covered	Requires prior authorization for plan to pay for therapy. If prior authorization is not obtained, no charges for those services will be covered by the plan. For medical diagnoses, limited to 30 total outpatient visits per calendar year for physical, occupational, and

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)	
				speech therapy for rehabilitation and habilitation services combined.
	Skilled nursing care	10% coinsurance	Not covered	Requires prior authorization for plan to pay for care. Limited to 100 days per lifetime. If prior authorization is not obtained, no charges for those services will be covered by the plan.
	Durable medical equipment	10% coinsurance	Not covered	Requires prior authorization for plan to pay for service. No charge for diabetic supplies. If prior authorization is not obtained, no charges for those services will be covered by the plan.
	Hospice services	10% coinsurance	Not covered	Requires prior authorization for plan to pay for service. Limited to 180 days per lifetime. If prior authorization is not obtained, no charges for those services will be covered by the plan.
If your child needs dental or eye care	Children's eye exam	$50 copay/visit	Not covered	Limited to one routine visit per calendar year and medically necessary visits for illness or injury. Deductible does not apply.
	Children's glasses	Not covered	Not covered	Excluded service.
	Children's dental check-up	Not covered	Not covered	Excluded service.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery (except reconstructive surgery necessary to repair a functional disorder from disease, injury, or congenital anomaly)
- Dental care (Adult and Child)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery (Subscribers only)
- Chiropractic care
- Routine eye care (Adult)
- Routine foot care (Diabetics only)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be

* For more information about limitations and exceptions, see the plan or policy document at https://www.vivahealth.com/Group/Login/

available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: VIVA HEALTH at 1-800-294-7780, the Alabama Department of Insurance at 334-241-4141, or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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

Does this plan meet the 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.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-800-294-7780 (TTY: 711).
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-294-7780 (TTY: 711).

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

* For more information about limitations and exceptions, see the plan or policy document at https://www.vivahealth.com/Group/Login/

About these Coverage Examples:

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

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

The plan's overall deductible	$500
Specialist copayment	$50
Hospital (facility) copayment	$250/day
Other cost-sharing	$0

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

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$660**

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

The plan's overall deductible	$500
Specialist copayment	$50
Hospital (facility) copayment	$250/day
Other coinsurance	10%

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

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$100
Copayments	$1,500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,620**

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

The plan's overall deductible	$500
Specialist copayment	$50
Hospital (facility) copayment	$250/day
Other coinsurance	10%

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

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$500
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,100**

Please Note: If you participate in your employer's HRA, a reimbursement can be made from your HRA account for certain qualified medical expenses (including deductibles and coinsurance) up to the balance available in your HRA. These numbers assume the patient received services from UAB Hospital. If you receive services from a different hospital, your costs may be higher.

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