VIVA HEALTH

CHILDREN'S OF ALABAMA

Effective Dates: January 1, 2023 – December 31, 2023

Attachment A to Certificate of Coverage – Summary of Benefits

The Plan's services and benefits, with their copayments/coinsurances and some of the limitations, are listed below. **Services received in a primary, specialty, or urgent care office may be subject to a copay or coinsurance in addition to the office visit cost-sharing depending on the type of service received.** 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
CALENDAR YEAR MEDICAL OUT-OF-POCKET MAXIMUM: The most a Member will pay per Calendar Year for qualified medical, mental, and substance abuse services. The maximum includes deductibles, copayments, and coinsurance paid by the Member for qualified services but does not include premiums, ancillary charges, prescription drug charges, or out-of-network charges over the maximum payment allowance. See the Certificate of Coverage for details.	$5,000 per individual; $10,000 per family
PREVENTIVE CARE: • Well Baby Care (Children under age 3) • Routine Physicals (One per Calendar Year for ages 3+) • Covered Immunizations • OB/GYN Preventive Visit (One per Calendar Year) • Preventive Prenatal Care • Other preventive items and services. See Certificate of Coverage for details.	100% Coverage
OTHER PRIMARY CARE SERVICES: *(Preventive Care and Other Office Visits)* • **Medical Physician Services** • **Hearing Exams** • **Illness and Injury** • **X-rays and Laboratory Procedures** ○ Covered Genetic Testing	$25 Copayment per visit 80% Coverage
SPECIALTY CARE: • **Medical Physician Services** • **OB/GYN Services** • **Illness and Injury** • **X-Ray and Laboratory Procedures** ○ Covered Genetic Testing	 $50 Copayment per visit 80% Coverage
URGENT CARE CENTER SERVICES: • **Medical Physician Services** • **Illness and Injury**	 $50 Copayment per visit
VISION CARE: *(limited to medically necessary visits for illness and injury; does not include annual eye exam)*	$50 Copayment per visit
ALLERGY SERVICES: • **Physician Services** • **Testing**	 $50 Copayment per visit 80% Coverage
DIAGNOSTIC SERVICES: *(Including but not limited to CT Scan, MRI, PET/SPECT, ERCP)*	80% Coverage
OUTPATIENT SERVICES: • **Surgery and Other Outpatient Services**	 $250 Copayment per service
HOSPITAL INPATIENT SERVICES: • **Physician Services** • **Semi-Private Room**	 100% Coverage $500 Copayment per admission
MATERNITY SERVICES:[1] • **Physician Services** *(Prenatal, delivery, and postnatal care)* • **Maternity Hospitalization**	 $50 Copayment per delivery $500 Copayment per admission
[1]Newborn care and other services covered only for enrolled child of employee or employee's spouse. Eligible child must be enrolled in plan within 30 days of birth or adoption for baby's care to be covered. No coverage for children of employee's dependent child.	
EMERGENCY ROOM SERVICES:	$150 Copayment per visit or $500 Copayment if involved in a motor vehicle accident and not wearing proper restraint (i.e. seatbelt, child safety seat, etc.)
EMERGENCY AMBULANCE SERVICES: *(Must be Medically Necessary)*	80% Coverage
DURABLE MEDICAL EQUIPMENT AND PROSTHETIC DEVICES:	80% Coverage
SKILLED NURSING FACILITY SERVICES: *(100 Days per Lifetime)*	80% Coverage
DIABETES SELF-MANAGEMENT EDUCATION:	$0 Copayment per visit
DIABETIC SUPPLIES: (*See diabetic supplies under prescription drug program*)	Not covered under medical coverage
REHABILITATION SERVICES: Physical, Speech, and Occupational Therapy *(Limited to 60 combined inpatient days and 20 combined outpatient visits per Calendar Year)*	80% Coverage
HOME HEALTH CARE SERVICES: *(Limited to 60 Visits per Calendar Year)*	80% Coverage
CHIROPRACTIC SERVICES: *(Covered up to 20 visits per Calendar Year)*	$40 Copayment per visit

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HEARING AIDS: *($3,000 maximum benefit per member every 3 years)*	80% Coverage
HEARING EXAM, TESTING, & HEARING AID SUPPLIES: Coverage includes charges in connection with the fitting and purchase of hearing aids, including hearing examinations and related services and supplies. Services must be rendered by a licensed audiologist. **Charges for hearing aid batteries are excluded.**	80% Coverage
TEMPOROMANDIBULAR JOINT DISORDER:	$40 Copayment per visit
SLEEP DISORDERS:	$40 Copayment per physician visit; 100% Coverage per sleep study
TRANSPLANT SERVICES:	$500 Hospital Copayment

VIVA HEALTH Customer Service: (205) 558-7474 or 1-800-294-7780

Visit our Website at www.vivahealth.com

ADDITIONAL BENEFITS	
MENTAL HEALTH & SUBSTANCE ABUSE SERVICES:	Benefits provided by **New Directions** (Plan #72385). Check with your benefits office for coverage information or contact New Directions at 866-292-3397.
VISION CARE:	Benefits provided by **VSP** and **EyeMed** through **Ameritas**. Check with your benefits office for coverage information or contact VSP at 800-877-7195 or EyeMed at 866-289-0614. You can also visit www.ameritas.com/group/olbc/childrensal.

PRESCRIPTION DRUG PROGRAM, Administered by Express Scripts

Children's of Alabama's prescription drug program for the VIVA HEALTH plan is administered through Express Scripts. Claims for prescription drugs and any complaints regarding the prescription drug program must be submitted to Express Scripts rather than to VIVA HEALTH, which administers all other benefits described in this Summary Plan Description. You can contact Express Scripts Customer Service at 877-417-7345 or by logging in to www.express-scripts.com if you should have any questions regarding your plan coverage. Certain drugs may be excluded under the formulary if prior authorization is not obtained from Express Scripts. The list of drugs is available by calling Express Scripts at 877-417-7345 or at www.express-scripts.com/2023drugs.

BENEFIT PERCENTAGE FOR PRESCRIPTION DRUGS: To permit the employee to receive the maximum benefits from this Plan, a mail order plan is available for maintenance and other specific medication. Plan participants will also be issued a drug card, which may be used at local participating pharmacies. A list of local participating pharmacies is online at www.express-scripts.com/NPF.

	Network Pharmacy 1 mo. supply	Mail Order 3 mo. supply
GENERIC SUBSTITUTE PRESCRIPTION DRUGS	$10 copay	$20 Copay
PREFERRED BRAND PRESCRIPTION DRUGS[2]	40% co-insurance up to a maximum of $75	40% co-insurance up to a maximum of $150
NON-PREFERRED BRAND PRESCRIPTION DRUGS	40% co-insurance up to a maximum of $150	40% co-insurance up to a maximum of $300
SPECIALTY/ BIOTECH DRUGS	40% co-insurance up to a maximum of $150	40% co-insurance up to a maximum of $300
DISPENSE AS WRITTEN PENALTY:	If you or your physician chooses a brand drug when a generic alternative is available, then you will be responsible for the 40% co-insurance PLUS the cost difference (ancillary charge) of the brand drug.	
DIABETIC SUPPLIES:	Diabetic supplies are subject to separate co-pays and co-insurance as stated above. However, if you are fully compliant in the Good Health Gateway Diabetes Rewards program insulin and diabetic supplies will be covered at 100%. Call 800-643-8028 for details.	
PRESCRIPTION DRUG BENEFIT PERIOD ANNUAL OUT-OF-POCKET MAXIMUM:	$2,500 per covered member up to $7,400 per family	
MAXIMUM DAY SUPPLY	30 day supply	90 day supply

[2]Annual out-of-pocket maximum does not apply to ancillary charge when a generic is available.

PRESCRIPTION DRUG PROGRAM EXCLUSIONS & LIMITATIONS

The following exclusions and limitations apply to expenses incurred by all Covered Persons and to all benefits provided by this Plan.

Charges for the following:

1. Medications available without prescription (over-the-counter drugs) except as required by the Affordable Care Act;
2. Experimental or investigational use drugs;
3. Therapeutic devices or appliances;
4. Ostomy supplies;
5. Appetite suppressants;
6. Non-prescription vitamins, except prenatal vitamins or as required by the Affordable Care Act;
7. Hair stimulant medications, such as Rogaine;
8. Biological agents, such as serums, toxoids;
9. Cosmetic indications and
10. Topical dental fluorides.

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PRE-EXISTING CONDITION POLICY: No pre-existing condition exclusions or waiting period.

ELIGIBLE DEPENDENT: Employee's lawful spouse who meets criteria set by Children's of Alabama and children of Eligible Employee under age 26 or disabled dependents who meet eligibility criteria.

ELIGIBILITY CRITERIA: You may enroll in this plan within 31 days of becoming an Eligible Employee if the following criteria are satisfied:

- you are an employee of Children's of Alabama;
- you are a Benefits Eligible Employee or a Variable Eligible Employee;
- and you are in a classification of employees that is covered by the plan.

TERMINATION OF COVERAGE: Coverage will cease on the last day of the pay period following employment termination or loss of eligibility except as defined below:

For an employee moving from a Benefits Eligible or Variable Eligible position to a position that no longer qualifies as Benefits Eligible or is expected to average less than 30 hours per week, coverage will terminate at the conclusion of the employee's Stability Period, unless the employee's hours of service qualify him or her as a Variable Eligible Employee for the following Stability Period.

- For an employee moving from a Benefits Eligible or Variable Eligible position to a position that no longer qualifies as Benefits Eligible or is expected to average less than 30 hours per week, the date the employee actively revokes coverage. Generally, coverage will continue to the end of the pay period in which the revocation occurs. This revocation of coverage is only permitted if the members losing coverage because of the revocation confirm enrollment in coverage under another plan that provides minimum essential coverage, and the new coverage is in place by the first day of the second month following the pay period in which coverage under this Plan is revoked.

For more information, refer to the COA Affordable Care Act Medical Eligibility Policy.

EMPLOYED SPOUSE PROVISION: Your spouse may NOT be covered as primary under this plan if:

- he or she is eligible for coverage under his or her employer's plan AND
- that employer pays at least 50% of total premium for individuals.

Your spouse may be eligible for secondary coverage under this plan if proof of other primary insurance is provided.

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).