VIVA ACCESS

Effective Dates: January 1, 2025 – December 31, 2025

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	TIER 1 COVERAGE UAB Network	TIER 2 COVERAGE VIVA Network (outside UAB)
CALENDAR YEAR MEDICAL DEDUCTIBLE: Applies to **all Tier 2 medical benefits when there is a cost-sharing differential between Tier 1 and Tier 2** and "after deductible" is noted on the Tier 2 member cost-sharing. Does not apply to prescription drugs or preventive care services covered at no charge. Amounts from manufacturer coupons or similar assistance programs used to satisfy Member Copayments or Coinsurance do not count toward the Deductible.	Not Applicable	$200 per individual; $600 per family
CALENDAR YEAR OUT-OF-POCKET MAXIMUM: The most a Member will pay per Calendar Year for qualified medical, mental, and substance use disorder 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. Amounts from manufacturer coupons or similar assistance programs used to satisfy Member Copayments or Coinsurance do not count toward the Out-of-Pocket Maximum.	$7,500 per individual; $15,000 per family	
PREVENTIVE CARE: • **Well Baby Care** (Children under age 3) • **Routine Physicals** (One per Calendar Year for ages 3+) • **Covered Immunizations** • **Preventive Prenatal Care** • **OB/GYN Preventive Visit** (One per Calendar Year) • **Nutritionist Preventive Visits** (Up to 3 /Calendar Yr w/ a Registered Dietitian or Nutritionist) • **Other preventive items and services** (See Certificate of Coverage for details)	100% Coverage	100% Coverage
OTHER PRIMARY CARE SERVICES: • **Medical Physician Services** • **Illness and Injury** • **Hearing Exams** • **X-Ray and Laboratory Procedures** ○ Covered Genetic Testing	$25 Copay/visit 80% Coverage	$30 Copay/visit after deductible 80% Coverage
SPECIALTY CARE: *(No PCP Referral Required)* • **Medical Physician Services** • **Illness and Injury** • **OB/GYN Services** • **X-Ray and Laboratory Procedures** ○ Covered Genetic Testing	$40 Copay/visit 80% Coverage	$50 Copay/visit after deductible 80% Coverage
URGENT CARE CENTER SERVICES: • **Medical Physician Services** • **Illness and Injury**	$25 Copay/visit at UAB Urgent Care; $40 Copay/visit at all other urgent care centers	$50 Copay/visit after deductible
VISION CARE: *(No PCP Referral Required)* • **One routine vision exam per Calendar Year** • **Other eye care office visits**	$40 Copay/visit $40 Copay/visit	$40 Copay/visit $40 Copay/visit
ALLERGY SERVICES: *(No PCP Referral Required)* • **Physician Services** • **Testing**	$40 Copay/visit 80% Coverage	$50 Copay/visit after deductible 80% Coverage
DIAGNOSTIC SERVICES: *(Including but not limited to CT Scan, MRI, PET/SPECT, ERCP)*	$100 Copay/service	$200 Copay/service after deductible
OUTPATIENT SERVICES: • **Surgery and Other Outpatient Services**	$150 Copay/visit	$250 Copay/visit after deductible
HOSPITAL INPATIENT SERVICES: • **Physician and Facility Services**	$250 Copay/*admission*	$250 Copay/*day* (Days 1-5) after deductible
INFERTILITY SERVICES: *(Subject to a $5,000 maximum family medical lifetime benefit and a separate $5,000 maximum family prescription drug lifetime benefit. Eligibility limited to subscriber and/or subscriber's spouse.)* • **Initial consultation and counseling session** • **Semen analysis, HSG test, and endometrial biopsy** • **Medically Necessary office visits and tests** (ultrasound, laboratory tests) • **Prescription drugs** • **Medical services to treat infertility** [assisted reproductive technology (ART), including intrauterine insemination (IUI) and in vitro fertilization (IVF)]	 $40 Copay/visit; One/Lifetime $0 Copay; One/Lifetime $40 Copay/visit Cost varies by tier $150 Copay/visit	*all medical services listed below covered after deductible: $50 Copay/visit; One/lifetime $0 Copay; One/Lifetime $50 Copay/visit Cost varies by tier $250 Copay/visit
MATERNITY SERVICES[1]: • **Physician Services** *(Prenatal, delivery, and postnatal care)* • **Maternity Hospitalization**	$40 Copay/delivery $250 Copay/admission	$50 Copay/delivery after deductible $250 Copay/day (Days 1-5) after deductible
EMERGENCY ROOM SERVICES: *(Copay waived if admitted within 24 hours)*	$100 Copay/visit	$100 Copay/visit

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MEDICAL BENEFITS	COVERAGE UAB Network	COVERAGE VIVA Network (outside UAB)
EMERGENCY AMBULANCE SERVICES: *(Must be Medically Necessary)*	80% Coverage	80% Coverage
DURABLE MEDICAL EQUIPMENT AND PROSTHETIC DEVICES:	80% Coverage	80% Coverage
SKILLED NURSING FACILITY SERVICES: *(Limited to 60 days per Calendar Year)*	80% Coverage	80% Coverage
HOME HEALTH CARE SERVICES: *(Limited to 60 visits per Calendar Year)*	80% Coverage	80% Coverage
DIABETES SELF-MANAGEMENT EDUCATION:	$40 Copay/visit	$50 Copay/visit after deductible
DIABETIC SUPPLIES: Insulin covered under prescription drug rider. For Diabetic Supplies call VIVA HEALTH.	100% Coverage	100% Coverage
MEDICAL NUTRITION SERVICES: *(Limited to 6 visits per Calendar Year with a Registered Dietitian or Nutritionist)*	$40 Copay/visit	$50 Copay/visit after deductible
REHABILITIATION AND HABILITATION SERVICES: Physical, Speech, and Occupational Therapy and Applied Behavior Analysis	$40 Copay/visit; $250 Copay/admission	$50 Copay/visit after deductible; $250 Copay/day (Days 1-5) after deductible
CHIROPRACTIC SERVICES: *(No PCP Referral Required)*	$40 Copay/visit	$50 Copay/visit after deductible
TEMPOROMANDIBULAR JOINT DISORDER:	$40 Copay/visit	$50 Copay/visit after deductible
SLEEP DISORDERS: • **Sleep Study**	$40 Copay/visit; $150 Copay/sleep study	$50 Copay/visit after deductible; $250 Copay/sleep study after deductible
TRANSPLANT SERVICES:	100% Coverage after $250 Hospital Copayment	100% Coverage after $250 Copay/day (Days 1-5) after deductible
MENTAL HEALTH & SUBSTANCE USE DISORDER SERVICES: • **Inpatient Services** • **Outpatient Services**	100% Coverage after $250 Copay/admission $40 Copay/visit	100% Coverage after $250 Copay/day (Days 1-5) after deductible $50 Copay/visit after deductible

PHARMACEUTICAL BENEFITS	COVERAGE
PHARMACY DEDUCTIBLE: Applies to all drugs except for weight loss drugs (which have a separate deductible), generic oral contraceptives, and other preventive drugs required by the Affordable Care Act. Amounts from manufacturer coupons or similar assistance programs used to satisfy Member Copayments or Coinsurance do not count toward the Deductible.	$150 per individual; $300 aggregate amount per family
COVERED PRESCRIPTION DRUGS[2]:	
• **Generic Drugs**	
○ From a Participating Pharmacy	$15 Copayment per 30-day supply
○ Mail-order	$30 Copayment per 90-day supply[3]
○ Participating Pharmacy	$45 Copayment per 90-day supply[3]
• **Preferred Brand Drugs**	
○ From a Participating Pharmacy	$45 Copayment per 30-day supply
○ Mail-order	$113 Copayment per 90-day supply[3]
○ Participating Pharmacy	$135 Copayment per 90-day supply[3]
• **Non-Preferred Brand Drugs**	
○ From a Participating Pharmacy	$70 Copayment per 30-day supply
○ Mail-order	$175 Copayment per 90-day supply[3]
○ Participating Pharmacy	$210 Copayment per 90-day supply[3]
• **Biological Drugs, Biotechnical Drugs, and Specialty Pharmaceuticals[4,5]**	80% Coverage
• **Oral Contraceptives**	$0 Copayment for generic and select brand drugs; Applicable Copayment for other brand drugs
• **Weight Loss Drugs (Contrave, Qsymia, Saxenda, and Wegovy)[6]**	70% Coverage after $200 weight loss drug deductible per member
• **Diabetic Testing Supplies**	100% Coverage

[1]Newborn care and other services covered only for enrolled child of employee or employee's spouse. Eligible baby 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. [2]Some medications may require prior authorization from VIVA HEALTH. For further information, please contact Customer Service at the phone number listed below. [3]A 90-day supply is as written by the provider, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. [4]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 https://www.vivahealth.com/Group/Login/. [5]Cost Sharing for certain specialty drugs may vary and be set to the maximum of any available manufacturer-funded copay assistance programs and is not applied to the deductible or out-of-pocket maximum. [6]Cost Sharing for weight loss drugs (Contrave, Qsymia, Saxenda, and Wegovy) does not apply to drugs prescribed for diabetes. Cost Sharing for drugs prescribed for diabetes follows standard formulary tiering.

When generic is available, Member pays difference between generic and Brand price, plus Copayment.
Check with your participating pharmacy to learn if it is eligible to offer a 90-day supply at retail.

SMOKING CESSATION PRODUCTS: 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

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DEPENDENT STUDENT BENEFITS: (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.
SABBATICAL: (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/uab

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.

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 (VIVA) network or the UAB network. The VIVA HEALTH (VIVA) 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, UAB St. Vincent's, The Kirklin Clinic, Medical West, UAB Callahan Eye Hospital, Spain Rehabilitation Center, and all UAB satellite clinics. **Note: UAB Network coverage cost-sharing (Tier 1) applies to employees in Huntsville, Selma, and Montgomery under benefit package VHU2 even when accessing care in the more expansive VIVA HEALTH network.**