




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

www.whyviva.com/MemberAccess.aspx. 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 .
Are there services covered before you meet your deductible ?	Yes. Preventive care , most drugs, dental care, 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?	Yes. \$50/individual or \$150/family for dental coverage. There are no other specific deductibles .	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these 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 www.myvivaprovider.com or call 1-800-294-7780 for a list of network providers .	This plan uses a provider network . You will pay less if you use a provider in the plan's 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	\$25 copay /visit	Not covered	Deductible does not apply. Teladoc telehealth service: \$45 copay /consultation
	Specialist visit	\$40 copay /visit	Not covered	Deductible does not apply. Chiropractic services limited to 25 visits per calendar year.
	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 /x-ray; \$7.50 copay /test for lab work at independent labs and 10% coinsurance /test for lab work at hospital-based labs	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 .
	Imaging (CT/PET scans, MRIs)	10% coinsurance /test	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)	\$5 copay /prescription (retail); \$12 copay /prescription (mail order)	Not covered	Covers up to a 31-day supply (retail); 90-day supply (mail order). No charge for select generic oral contraceptive drugs. Deductible does not apply.
	Tier 2 Drugs (non-preferred generic drugs)	\$20 copay /prescription (retail); \$43 copay /prescription (mail order)	Not covered	Covers up to a 31-day supply (retail); 90-day supply (mail order). No charge for select generic oral contraceptive drugs. Deductible does not apply.
	Tier 3 Drugs (preferred brand and non-preferred generic drugs)	\$60 copay /prescription (retail); \$150 copay /prescription (mail order)	Not covered	Covers up to a 31-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.
	Tier 4 Drugs (non-preferred brand and non-preferred)	\$80 copay /prescription (retail); \$200 copay /prescription (mail order)	Not covered	Covers up to a 31-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

* For more information about limitations and exceptions, see the plan or policy document at www.vivaemployer.com/PlanDocuments/?Package=PEHP.

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)	
	generic drugs)			not apply.
	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)	\$150 copay /service at an ambulatory surgical center; 10% coinsurance /service at an Outpatient Hospital	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 services at an ambulatory surgical center.
	Physician/surgeon fees	No charge	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 .
If you need immediate medical attention	Emergency room care	\$200 copay /visit	\$200 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	20% coinsurance	20% coinsurance	Limited to transportation to a hospital.
	Urgent care	\$40 copay /visit	\$40 copay /visit	Coverage from non-participating providers is limited to care outside the VIVA HEALTH 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)	\$200 copay /admission; \$50 copay /day (days 2-5 only)	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 . Outpatient procedures that result in a member being placed in hospital observation will be covered under the outpatient surgery benefit. Hospital observation stays when no procedure is performed that do not result in an inpatient admission will be covered with a \$200 copay . Deductible does not apply.

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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)	
	Physician/surgeon fees	No charge	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 .
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$40 copay /visit	Not covered	Limited to office visits and certain conditions. See plan documents for more information. Partial Hospitalization and 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	\$200 copay /admission; \$50 copay /day (days 2-5 only)	Not covered except for emergency medical conditions	Limited to hospital inpatient care. 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	\$40 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.
	Childbirth/delivery professional services	No charge	Not covered	
	Childbirth/delivery facility services	\$200 copay /admission; \$50 copay /day (days 2-5 only)	Not covered	
If you need help recovering or have other special health needs	Home health care	No charge	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	20% coinsurance ; \$200 copay /admission; \$50 copay /day (days 2-5 only)	Not covered	Requires prior authorization for plan to pay for therapy. Limited to 25 total outpatient visits per calendar year for physical, occupational, and speech therapy and 60 inpatient days for rehabilitation. If prior authorization is not obtained, no charges for those services will be covered by the plan . Deductible does not apply to admission and daily copay.
	Habilitation services	20% coinsurance	Not covered	Requires prior authorization for plan to pay for therapy. Limited to diagnosis of Autism, Autism Spectrum Disorder, or Pervasive Developmental Delay. If prior authorization is not obtained, no charges for those services will be covered by the plan .

* For more information about limitations and exceptions, see the plan or policy document at www.vivaemployer.com/PlanDocuments/?Package=PEHP.

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)	
	Skilled nursing care	20% 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	20% coinsurance	Not covered	Requires prior authorization for plan to pay for service. If prior authorization is not obtained, no charges for those services will be covered by the plan .
	Hospice services	No charge	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	\$40 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	No charge	Not covered	Limited to \$500 per calendar year.

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 .)		
<ul style="list-style-type: none"> Acupuncture Bariatric surgery Cosmetic surgery (except reconstructive surgery necessary to repair a functional disorder from disease, injury, or congenital anomaly) 	<ul style="list-style-type: none"> Glasses Hearing aids Infertility treatment Long term care 	<ul style="list-style-type: none"> 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.)		
<ul style="list-style-type: none"> Chiropractic care Dental care (Children and adults) 	<ul style="list-style-type: none"> Routine eye care (Adult) 	<ul style="list-style-type: none"> 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 Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.gms.gov. Other coverage options may be 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 or the Alabama Department of Insurance at 334-241-4141.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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](#).

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

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](#) \$40
- Hospital (facility) [copayment](#) \$200
- 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 \$12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$300
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$360

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](#) \$40
- Hospital (facility) [copayment](#) \$200
- Other [cost-sharing](#) \$0

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 \$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$1,300
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
The total Joe would pay is	\$1,360

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

- The [plan's](#) overall [deductible](#) \$500
- [Specialist copayment](#) \$40
- Hospital (facility) [copayment](#) \$200
- Other [coinsurance](#) 10/20%

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 \$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles	\$500
Copayments	\$100
Coinsurance	\$200
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$800