INFIRMARY HEALTH

Effective Dates: January 1, 2024 – December 31, 2024

Attachment A to Certificate of Coverage

The Plan's services and benefits, with their copayments, coinsurance, 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	TIER 1 COVERAGE Infirmary Health Network (CIN*)	TIER 2 COVERAGE VIVA HEALTH Network (Outside CIN**)
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.	$7,000 per individual; $14,000 per family	
CALENDAR YEAR DEDUCTIBLE: Applies ONLY to those benefits with coinsurance coverage when the Member pays a set percentage of the cost. Does not apply to benefits with a copayment.	$1,000 per individual; $3,000 per family	$3,000 per individual
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** • **Nutritionist Preventive Visits** (Up to 3 per Calendar Year with a Registered Dietitian or Nutritionist) • **Other preventive items and services** (See vivahealth.com/infirmaryhealth) for a listing of specific preventive services and immunizations)	100% Coverage	100% Coverage
OTHER PRIMARY CARE SERVICES: • **Medical Physician Services** • **Illness and Injury** • **Hearing Exams**	$30 Copayment per visit	$55 Copayment per visit
SPECIALTY CARE: *(No PCP Referral Required. Specialty care received from an in-network pediatrician or dermatologist is covered at the lower Tier 1 copayment.)* • **Medical Physician Services** • **Illness and Injury** • **OB/GYN Services**	$30 Copayment per visit	$55 Copayment per visit
URGENT CARE CENTER SERVICES: • **Medical Physician Services** • **Illness and Injury**	$30 Copayment per visit	$55 Copayment per visit
VISION CARE: *(No PCP Referral Required)* • **One routine vision exam per Calendar Year** • **Other eye care office visits**	$30 Copayment per visit	$55 Copayment per visit
ALLERGY SERVICES: *(No PCP Referral Required)* • **Physician Services** • **Testing**	$30 Copayment per visit 90% Coverage	$55 Copayment per visit 50% Coverage
X-RAY AND LABORATORY PROCEDURES: • **Performed in the Physician's Office** • **Performed in Outpatient Settings** • **Covered Genetic Testing**	100% Coverage after Copayment 90% Coverage 90% Coverage	100% Coverage after Copayment 50% Coverage 50% Coverage
DIAGNOSTIC SERVICES: *(Including but not limited to CT Scan, MRI, PET/SPECT, ERCP)* • **Performed in the Physician's Office** • **Performed in Outpatient Settings**	100% Coverage after Copayment 90% Coverage	100% Coverage after Copayment 50% Coverage
CHRONIC CARE MAINTENANCE: (*Including but not limited to dialysis, radiation therapy, wound care, wound therapy)* • **Performed in the Physician's Office** • **Performed in Outpatient Settings**	100% Coverage after Copayment 90% Coverage	100% Coverage after Copayment 50% Coverage
OUTPATIENT SERVICES: • **Surgery and Other Outpatient Services**	90% Coverage	50% Coverage
HOSPITAL INPATIENT SERVICES: • **Physician and Facility Services**	90% Coverage	50% Coverage
MATERNITY SERVICES[1]: • **Physician Services** *(Prenatal, delivery, and postnatal care)* • **Maternity Hospitalization** [1]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.	$30 Copayment 90% Coverage	$55 Copayment 50% Coverage
EMERGENCY ROOM SERVICES: *(Waived if admitted within 24 hours)*	$250 Facility Copayment per visit $50 Physician Copayment per visit	$250 Facility Copayment per visit $50 Physician Copayment per visit
EMERGENCY AMBULANCE SERVICES: *(Must be Medically Necessary)*	$200 Copayment	$200 Copayment

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MEDICAL BENEFITS	TIER 1 COVERAGE Infirmary Health Network (CIN*)	TIER 2 COVERAGE VIVA HEALTH Network (Outside CIN**)
SKILLED NURSING FACILITY SERVICES: *(Limited to 60 days per Calendar Year)*	90% Coverage	50% Coverage
MEDICAL NUTRITION SERVICES: *(Limited to 6 visits per Calendar Year with a Registered Dietitian or Nutritionist)*	$30 Copayment per visit	$55 Copayment per visit
DIABETES SELF-MANAGEMENT EDUCATION:	$30 Copayment per visit	$55 Copayment per visit
DIABETIC SUPPLIES:	See Pharmacy Benefits	See Pharmacy Benefits
DURABLE MEDICAL EQUIPMENT AND PROSTHETIC DEVICES: • **Wigs for chemotherapy patients**	75% Coverage 90% Coverage	75% Coverage 90% Coverage
HEARING AIDS AND SUPPLIES: *($5,000 maximum benefit per member every 36 months. **Charges for hearing aid batteries are excluded.**)*	50% Coverage	50% Coverage
HEARING EXAM & TESTING: Coverage includes charges in connection with the fitting of hearing aids, including hearing examinations and related services. Services must be rendered by a licensed audiologist.	$30 Copayment per visit	$55 Copayment per visit
REHABILITIATION SERVICES: Physical, Speech, and Occupational Therapy	90% Coverage	50% Coverage
HABILITIATION SERVICES: Physical, Speech, and Occupational Therapy and Applied Behavior Analysis	90% Coverage	90% Coverage
CHIROPRACTIC SERVICES: *(No PCP Referral Required)*	$35 Copayment per visit	$35 Copayment per visit
HOME HEALTH CARE SERVICES: *(Limited to 90 visits per Calendar Year with prior authorization)*	90% Coverage	50% Coverage
TEMPOROMANDIBULAR JOINT DISORDER: • **Physician Services** • **Inpatient/Outpatient Services**	 $30 Copayment per visit; 90% Coverage	 $55 Copayment per visit; 50% Coverage
SLEEP DISORDERS: • **Sleep Study**	$30 Copayment per visit; 90% Coverage per sleep study	$55 Copayment per visit; 50% Coverage per sleep study
TRANSPLANT SERVICES:	90% Coverage	50% Coverage
MENTAL HEALTH & SUBSTANCE USE DISORDER SERVICES: • **Outpatient Services** • **Inpatient Services**	 $30 Copayment per visit; 90% Coverage	 $55 Copayment per visit; 90% Coverage

PRESCRIPTION DRUG PROGRAM, Administered by *Rx Benefits*

PHARMACY DEDUCTIBLE: Applies to all drugs except for generic oral contraceptives and other preventive drugs required by the Affordable Care Act.	$100 per individual not to exceed $300 per family; Copayments apply after deductible is met

PHARMACY[2]:	CO-PAY AMOUNT:	PRESCRIPTION TYPE:	90 DAY SUPPLY CO-PAY:
RX4U	$0	Generic Blood Pressure Medications	$0
	$0	Diabetic Supplies[3]	$0
	½ off Insulin and Asthma medications	Active Diabetics or Asthma Chronic Care Management participant with MedCom Care Management	½ off Insulin and Asthma medications
	$4	Generic Medications	$10
	$25	Preferred Brand	$63
	$35	Non-Preferred Brand	$87
	$200	Specialty Medications	30 days only
OTHER PHARMACY PROVIDERS:	$0	Diabetic Supplies[3]	$0
	$25	Generic Medications	$62.50
	$65	Preferred Brand	$162.50
	$85	Non-Preferred Brand	$212.50
IMPORTANT NOTE*: Specialty Medications are only filled outside of RX4U if not available at RX4U. Contact Infirmary Health HR at 251-435-2211 with questions.*			30 days only

[2]If generic is available and Brand is selected, member will be responsible for the difference in price. [3]No copay or deductible for diabetic supplies (syringes, lancets, needles, monitors, and strips) as long as a prescription is presented at the pharmacy.

For further information, please contact RX Benefits Member Services at 1-800-334-8134 or rxhelp@rxbenefits.com

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

NETWORK

*The Infirmary Health Clinically Integrated Network (CIN) means Mobile Infirmary, Thomas Hospital, North Baldwin Infirmary, and all other Infirmary satellites and UAB. UAB means UAB Hospital, UAB Women and Infants Center, UAB Highlands, The Kirklin Clinic of UAB Hospital, Medical West, UAB Callahan Eye Hospital, UAB Spain Rehabilitation Center, and all UAB satellite clinics. Please check the VIVA HEALTH provider directory at www.vivahealth.com/infirmaryhealth for a listing of the physicians and other providers within the Infirmary Health CIN.

**The VIVA HEALTH network includes hospitals, health centers, and other providers contracted with VIVA HEALTH but outside of the Infirmary Health CIN.

***Tier 1 coverage applies to DaVita and Fresenius dialysis clinics.

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).