



For Employees of The Health Care Authority of the City of Anniston



**The Health Care Authority of the  
City of Anniston – VIVA Guidebook 2026**



Dear Employees of The Health Care Authority of the City of Anniston,

VIVA HEALTH, located in Birmingham, AL, is part of the University of Alabama at Birmingham (UAB) Health System. VIVA HEALTH is one of the largest health insurers in the state, with over 100,000 Medicare and commercial lives. We are pleased to have the opportunity to offer health insurance coverage to RMC Health System employees and their families. Since we started in 1995, VIVA HEALTH has grown to be one of the largest health plans in the State of Alabama. Like RMC Health System, we pride ourselves on offering an outstanding value, service, and network to our members.

The VIVA HEALTH-RMC Health System Plan is a tiered network plan that consists of RMC Health System medical providers on tier 1, UAB Health System and Children's Hospital medical providers on tier 2, and the remaining VIVA HEALTH network on tier 3. This plan includes access to primary care and all medical specialties. The plan also includes telehealth services that link members to Alabama-licensed physicians through phone or video chat for the treatment of minor medical concerns, improving the affordability and convenience of primary care. On the VIVA HEALTH-RMC Health System Plan, out-of-network services are only available for urgently needed or emergency care or when approved by VIVA HEALTH's medical director.

If you have any questions, we invite you to contact our customer service department Monday through Friday from 8AM to 5PM at (205) 558-7474, toll-free at (800) 294-7780 (TTY 711), and by email at [vivamemberhelp@uabmc.edu](mailto:vivamemberhelp@uabmc.edu).

Thank you for considering VIVA HEALTH as your health plan in 2025.  
We look forward to serving you.

Sincerely,



Brad Rollow  
CEO/President

# What You Need to Know

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**As a VIVA HEALTH-RMC Health System member, you have access to RMC Health System, the world-renowned UAB Health System, and VIVA HEALTH's full network of providers.**

## How the VIVA HEALTH-RMC Health System Plan Works

Members on this plan may see any VIVA HEALTH participating provider for their health care. However, if you see a provider within the RMC or UAB+ network, you may enjoy cost savings through lower copays, coinsurance, and deductibles.

The RMC network (Tier 1) offers the lowest copays, coinsurance, and deductibles of any of the three coverage tiers. The RMC network consists of Regional Medical Center, Stringfellow Memorial Hospital, and all RMC satellite clinics.

The UAB+ network (Tier 2) offers copays, coinsurance, and deductibles a little higher than the RMC (Tier 1) network, but includes access to University Hospital, UAB Women and Infants Center, UAB Highlands, The Kirklin Clinic, Medical West, UAB Callahan Eye Hospital, Spain Rehabilitation Center, all UAB satellite clinics, and Children's Hospital.

The VIVA HEALTH network (Tier 3) has the highest copays, coinsurance, and deductibles on the Plan but includes hospitals and health centers contracted with VIVA HEALTH but outside of RMC and UAB+.

## Will my doctor be covered under the VIVA HEALTH-RMC Health System Plan?

All physicians within VIVA HEALTH's robust state-wide network are covered under the VIVA HEALTH-RMC Health System plan. However, your costs may be less if you use a provider at RMC Health System, UAB Health System, or Children's of Alabama. To determine which tier your provider or a facility is in, you can call VIVA HEALTH at 1-800-294-7780. Remember: medical care you receive from providers who are not included in the VIVA HEALTH-RMC Health System Plan network will not be covered by the plan unless it is urgently needed or emergency medical care or approved by VIVA HEALTH's medical director in advance.

## Worldwide Emergency and Urgent Care Coverage

If you are outside the service area and have an urgent and unforeseen need for care that can't wait until you return home, you are covered. This includes care in a physician's office for an unexpected illness or injury that would not be classified as an emergency, but does require immediate attention. Care in an emergency room is only covered for treatment of emergency medical conditions. Of course, this does not include routine or elective medical services, and you must return to the service area for any follow-up care. Still, if you're on a weekend trip or an extended vacation, you can relax knowing that you are covered.

## Excellent Customer Service

We encourage you to put us to the test: When you dial the VIVA HEALTH Customer Service department during business hours (8am - 5pm, Monday through Friday), you'll get a real person with real answers. You can also have your questions answered at the click of the mouse! By visiting our website at [www.VivaHealth.com](http://www.VivaHealth.com), you can access all of the following information:

- Summary of Benefits
- Certificate of Coverage
- Wellness Benefits
- Access our Member Portal ([www.VivaMembers.com](http://www.VivaMembers.com)) or send an email to [VivaMemberHelp@uabmc.edu](mailto:VivaMemberHelp@uabmc.edu) to request a new ID card, change your PCP, update your mailing address, or inquire about a claim.





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## 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.

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*<br>RMC/Stringfellow Network                                             | TIER 2 COVERAGE**<br>UAB+ Network                                                   | TIER 3 COVERAGE***<br>VIVA HEALTH Network                                                |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|
| <b>CALENDAR YEAR OVERALL DEDUCTIBLE:</b> Applies ONLY to those benefits with coinsurance coverage when the Member pays a set percentage of the cost and it is not otherwise noted that the benefit coinsurance is exempted from the deductible or when "100% Coverage, subject to the deductible" is noted. Does not apply to benefits with a copayment. Does not apply to Specialty Drugs ordered through the pharmacy benefit but will apply to such drugs when provided directly by a physician or hospital. See separate pharmacy deductibles on next page. Deductible amounts paid on any tier apply toward all tiers, but Tier 3 has a higher deductible requirement. Amounts from manufacturer coupons or similar assistance programs used to satisfy Member Copayments or Coinsurance do not count toward the Deductible. |                                                                                                                                                                                                                                                                                                                                                                    | \$1,500 per family, not to exceed \$500 per any individual                               | \$500 per individual;<br>\$1,500 per family, not to exceed \$500 per any individual | \$3,000 per individual;<br>\$6,000 per family, not to exceed \$3,000 per any individual  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | <b>PER ADMISSION INPATIENT HOSPITAL DEDUCTIBLE:</b> Applies ONLY to each inpatient hospital admission in a Tier 2 or Tier 3 hospital. Inpatient hospital deductible counts toward the Calendar Year Overall Deductible but will be charged at each Tier 2 and Tier 3 inpatient hospital admission until the applicable Calendar Year Out-of-Pocket Maximum is met. | No Charge                                                                                | \$500 per admission                                                                 | \$3,000 per admission                                                                    |
| <b>CALENDAR YEAR OUT-OF-POCKET MAXIMUM:</b> 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, ancillary charges, or out-of-network charges over the maximum payment allowance. Out-of-pocket cost sharing paid on any tier applies toward all tiers, but Tier 3 has a higher out-of-pocket maximum. Amounts from manufacturer coupons or similar assistance programs used to satisfy Member Copayments or Coinsurance do not count toward the Out-of-Pocket Maximum.                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                    | \$5,000 per individual;<br>\$10,000 per family, not to exceed \$5,000 per any individual | \$100% Coverage                                                                     | \$6,000 per individual;<br>\$12,000 per family, not to exceed \$6,000 per any individual |
| <b>PREVENTIVE CARE:</b> <ul style="list-style-type: none"><li>Well Baby Care (Children under age 3)</li><li>Routine Physicals (One per Calendar Year for ages 3+)</li><li>Covered Immunizations</li><li>Preventive Prenatal Care</li><li>OB/GYN Preventive Visit (One per Calendar Year)</li><li>Nutritionist Preventive Visits (Up to 3 per Calendar Year with a Registered Dietitian or Nutritionist)</li><li>Other preventive items and services (See Certificate of Coverage for recommendations and guidelines)</li></ul>                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                    | 100% Coverage                                                                            | 100% Coverage                                                                       | 100% Coverage                                                                            |
| <b>OTHER PRIMARY CARE SERVICES:</b> <ul style="list-style-type: none"><li>Medical Physician Services</li><li>Illness and Injury</li><li>Hearing Exams</li></ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                    | \$30 Copayment per visit                                                                 | \$30 Copayment per visit                                                            | \$30 Copayment per visit                                                                 |
| <b>SPECIALTY CARE: (No PCP Referral Required)</b> <ul style="list-style-type: none"><li>Medical Physician Services</li><li>Illness and Injury</li><li>OB/GYN Services</li></ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                    | \$45 Copayment per visit                                                                 | \$45 Copayment per visit                                                            | \$45 Copayment per visit                                                                 |
| <b>URGENT CARE CENTER SERVICES:</b> <ul style="list-style-type: none"><li>Medical Physician Services</li><li>Illness and Injury</li></ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                    | \$45 Copayment per visit                                                                 | \$45 Copayment per visit                                                            | \$45 Copayment per visit                                                                 |
| <b>TELADOC TELEHEALTH SERVICES:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                    | \$10 per consultation                                                                    |                                                                                     |                                                                                          |
| <b>EMERGENCY ROOM SERVICES: (Cost sharing waived if admitted within 24 hours)</b> <ul style="list-style-type: none"><li>Facility Services</li><li>Physician Services</li></ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                    | \$150 Copayment per visit<br>\$50 Copayment per visit                                    | \$150 Copayment per visit<br>\$50 Copayment per visit                               | \$150 Copayment per visit<br>\$50 Copayment per visit                                    |
| <b>EMERGENCY AMBULANCE SERVICES: (Must be Medically Necessary)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                    | 80% Coverage                                                                             |                                                                                     |                                                                                          |







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| MEDICAL BENEFITS                                                                                                                                                                                                                                                                                                                      | TIER 1 COVERAGE*<br>RMC/Stringfellow Network                              | TIER 2 COVERAGE**<br>UAB+ Network                                                                               | TIER 3 COVERAGE***<br>VIVA HEALTH Network                                                                         |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------|
| <b>HOSPITAL INPATIENT SERVICES:</b> <ul style="list-style-type: none"><li>Facility Services</li><li>Physician Services</li></ul>                                                                                                                                                                                                      | 100% Coverage<br>90% Coverage                                             | 90% Coverage <i>plus</i> \$500 per admission hospital deductible<br>90% Coverage                                | 70% Coverage <i>plus</i> \$3,000 per admission hospital deductible<br>70% Coverage                                |
| <b>SECOND SURGICAL OPINION:</b>                                                                                                                                                                                                                                                                                                       | 90% Coverage (no deductible)                                              | 90% Coverage (no deductible)                                                                                    | 70% Coverage (no deductible)                                                                                      |
| <b>OUTPATIENT SERVICES:</b> <ul style="list-style-type: none"><li>Facility Services</li><li>Physician Services</li></ul>                                                                                                                                                                                                              | \$100 Copayment <sup>1</sup><br>90% Coverage                              | 90% Coverage<br>90% Coverage                                                                                    | 70% Coverage<br>70% Coverage                                                                                      |
| <b>MATERNITY SERVICES<sup>2</sup>:</b> <ul style="list-style-type: none"><li>Physician Prenatal and Postnatal Services</li><li>Physician Delivery Services</li><li>Maternity Hospitalization</li></ul>                                                                                                                                | \$45 Copayment per delivery<br>90% Coverage<br>100% Coverage              | \$45 Copayment per delivery<br>90% Coverage<br>90% Coverage <i>plus</i> \$500 per admission hospital deductible | \$45 Copayment per delivery<br>70% Coverage<br>70% Coverage <i>plus</i> \$3,000 per admission hospital deductible |
| <b>DIAGNOSTIC SERVICES:</b> <ul style="list-style-type: none"><li>X-Rays, laboratory procedures and other diagnostic services (<i>Including, but not limited to, covered genetic testing, CT Scan, MRI, PET/SPECT, ERCP</i>)</li><li>Physician interpretation fees for diagnostic services</li><li>Other Physician services</li></ul> | 100% Coverage<br>90% Coverage (no deductible)<br>90% Coverage             | 90% Coverage<br>90% Coverage (no deductible)<br>90% Coverage                                                    | 70% Coverage<br>70% Coverage<br>70% Coverage                                                                      |
| <b>CHRONIC CARE MAINTENANCE:</b> ( <i>Inpatient and outpatient only. Not covered in physician's office.</i> ) <ul style="list-style-type: none"><li>Chemotherapy, radiation therapy, wound care, and wound therapy</li><li>IV therapy</li><li>Physician fees for chronic care maintenance</li></ul>                                   | 100% Coverage<br>100% Coverage<br>90% Coverage (no deductible)            | 90% Coverage<br>Not Covered<br>90% Coverage (no deductible)                                                     | 70% Coverage<br>Not Covered<br>70% Coverage                                                                       |
| <b>DIALYSIS:</b> <ul style="list-style-type: none"><li>Outpatient Dialysis</li><li>Physician Fees</li></ul>                                                                                                                                                                                                                           | 90% Coverage<br>100% Coverage (subject to the deductible)                 | 90% Coverage<br>100% Coverage (subject to the deductible)                                                       | 90% Coverage<br>70% Coverage                                                                                      |
| <b>VISION CARE:</b> ( <i>No PCP Referral Required</i> ) <ul style="list-style-type: none"><li>Illness and Injury</li></ul>                                                                                                                                                                                                            | \$45 Copayment per visit                                                  | \$45 Copayment per visit                                                                                        | \$45 Copayment per visit                                                                                          |
| <b>ALLERGY SERVICES:</b> ( <i>No PCP Referral Required</i> ) <ul style="list-style-type: none"><li>Physician Services</li><li>Testing and Treatment</li></ul>                                                                                                                                                                         | \$45 Copayment<br>80% Coverage                                            | \$45 Copayment<br>80% Coverage                                                                                  | \$45 Copayment<br>80% Coverage                                                                                    |
| <b>DURABLE MEDICAL EQUIPMENT AND PROSTHETIC DEVICES:</b>                                                                                                                                                                                                                                                                              |                                                                           | 80% Coverage                                                                                                    |                                                                                                                   |
| <b>SKILLED NURSING FACILITY SERVICES:</b> ( <i>Limited to 100 days per Lifetime</i> )                                                                                                                                                                                                                                                 | Not Available                                                             | 90% Coverage                                                                                                    | 70% Coverage                                                                                                      |
| <b>MEDICAL NUTRITION SERVICES:</b> ( <i>Limited to 6 visits per Calendar Year with a Registered Dietitian or Nutritionist</i> )                                                                                                                                                                                                       | \$45 Copayment per visit<br>\$45 Copayment per visit                      | \$45 Copayment per visit<br>\$45 Copayment per visit                                                            | \$45 Copayment per visit<br>\$45 Copayment per visit                                                              |
| <b>DIABETES SELF-MANAGEMENT EDUCATION:</b>                                                                                                                                                                                                                                                                                            | Not covered under the medical benefit. See pharmacy benefit for coverage. |                                                                                                                 |                                                                                                                   |
| <b>DIABETIC SUPPLIES:</b>                                                                                                                                                                                                                                                                                                             |                                                                           |                                                                                                                 |                                                                                                                   |
| <b>REHABILITATION AND HABILITATION SERVICES:</b> Physical, Speech, and Occupational Therapy and Applied Behavior Analysis ( <i>Limited to 60 total inpatient days and 30 total outpatient visits per Calendar Year for medical diagnoses</i> )                                                                                        | 90% Coverage<br>(no deductible)                                           | 90% Coverage<br>(no deductible)                                                                                 | 70% Coverage<br>(no deductible)                                                                                   |
| <b>CHIROPRACTIC SERVICES:</b> ( <i>No PCP Referral Required. Limited to 25 visits per Calendar Year.</i> ) <ul style="list-style-type: none"><li>Physician Services</li><li>Testing and Treatment</li></ul>                                                                                                                           | \$45 Copayment<br>80% Coverage                                            | \$45 Copayment<br>80% Coverage                                                                                  | \$45 Copayment<br>80% Coverage                                                                                    |
| <b>HOME HEALTH CARE SERVICES:</b> ( <i>Limited to 60 visits per Calendar Year</i> )                                                                                                                                                                                                                                                   |                                                                           | 80% Coverage                                                                                                    |                                                                                                                   |
| <b>TEMPOROMANDIBULAR JOINT DISORDER:</b>                                                                                                                                                                                                                                                                                              | \$45 Copayment per visit                                                  | \$45 Copayment per visit                                                                                        | \$45 Copayment per visit                                                                                          |
| <b>SLEEP DISORDERS:</b> <ul style="list-style-type: none"><li>Sleep Study</li></ul>                                                                                                                                                                                                                                                   | \$45 Copayment per visit;<br>90% Coverage per sleep study                 | \$45 Copayment per visit;<br>90% Coverage per sleep study                                                       | \$45 Copayment per visit;<br>70% Coverage per sleep study                                                         |





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| MEDICAL BENEFITS                                                                                                                                                                                             | TIER 1 COVERAGE*<br>RMC/Stringfellow Network | TIER 2 COVERAGE**<br>UAB+ Network                                      | TIER 3 COVERAGE***<br>VIVA HEALTH Network                                |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------|
| <b>TRANSPLANT SERVICES:</b> <ul style="list-style-type: none"><li>Facility Services</li><li>Physician Services</li></ul>                                                                                     | Not Available                                | 90% Coverage plus \$500 per admission hospital deductible 90% Coverage | 70% Coverage plus \$3,000 per admission hospital deductible 70% Coverage |
| <b>MENTAL HEALTH &amp; SUBSTANCE USE DISORDER INPATIENT SERVICES:</b> <ul style="list-style-type: none"><li>Inpatient Facility Services</li><li>Inpatient Physician Services</li></ul>                       | 100% Coverage 90% Coverage                   | 90% Coverage plus \$500 per admission hospital deductible 90% Coverage | 70% Coverage plus \$3,000 per admission hospital deductible 70% Coverage |
| <b>MENTAL HEALTH &amp; SUBSTANCE USE DISORDER OUTPATIENT SERVICES:</b> <ul style="list-style-type: none"><li>Outpatient Services</li><li>Intensive Outpatient Services and Partial Hospitalization</li></ul> | \$45 Copayment per visit 100% Coverage       | \$45 Copayment per visit 100% Coverage                                 | \$45 Copayment per visit 100% Coverage                                   |

## NOTES

\*Outpatient facility services received at The Surgery Center in Oxford, AL (TSC) are subject to 10% coinsurance (deductible does not apply) in addition to the \$100 copayment.  
\*Eligible baby must be enrolled in plan within 30 days of birth or adoption for baby's care to be covered.

## NETWORK

\*\*"RMC" means Regional Medical Center Anniston, Stringfellow Memorial Hospital, and all RMC satellite clinics.

\*\*\*The UAB+ network (Tier 2) includes University Hospital, UAB Women and Infants Center, UAB Highlands, The Kirklin Clinic, Medical West, UAB Callahan Eye Hospital, Spain Rehabilitation Center, all UAB satellite clinics, and Children's of Alabama.

\*\*\*The Viva Health network (Tier 3) includes hospitals and health centers contracted with Viva Health but outside of RMC and UAB.

| PHARMACEUTICAL BENEFITS, Administered by<br>Proxys/MedOne | TIER 1 COVERAGE<br>The Pharmacy at RMC      | TIER 2 COVERAGE<br>Select Local Pharmacies   | TIER 3 COVERAGE<br>All Other Pharmacies      |
|-----------------------------------------------------------|---------------------------------------------|----------------------------------------------|----------------------------------------------|
| Pharmaceutical Deductible                                 | \$100 Brand Name Deductible                 | \$200 Brand Name Deductible                  | \$300 Brand Name Deductible                  |
| Generic Drugs                                             | \$8 (30 day supply)   \$16 (90 day supply)  | \$20 (30 day supply)   \$40 (90 day supply)  | \$25 (30 day supply)   \$50 (90 day supply)  |
| Preferred Brand Name Drugs                                | \$25 (30 day supply)   \$50 (90 day supply) | \$45 (30 day supply)   \$90 (90 day supply)  | \$55 (30 day supply)   \$110 (90 day supply) |
| Non-Preferred Brand Name Drugs                            | \$45 (30 day supply)   \$90 (90 day supply) | \$70 (30 day supply)   \$140 (90 day supply) | \$80 (30 day supply)   \$160 (90 day supply) |
| Specialty Drugs                                           | 70% Coverage (30 day supply only)           | 70% Coverage (30 day supply only)            | 70% Coverage (30 day supply only)            |
| Mail Order                                                | Mail order not covered                      | Mail order not covered                       | Mail order not covered                       |

Viva Health Customer Service: (205) 558-7474 or 1-800-294-7780 | Visit our Website at [www.vivahealth.com/rmc](http://www.vivahealth.com/rmc)

Eligible Dependent:

Eligible Employee's lawful eligible spouse, children of Eligible Employees up to age 26, and disabled dependents who meet eligibility criteria.

Working Spouse Rule:

Working spouses are NOT eligible for coverage under this plan if health care coverage is available through their employer's plan and they are eligible to enroll for such coverage.

Pre-Existing Condition Policy:

No pre-existing condition exclusions or waiting period.







# Wellness Benefits

## The Health Care Authority of the City of Anniston



This schedule outlines preventive services and items that VIVA HEALTH will pay at 100% for its non-grandfathered “Wellness” plans. Many of the services are provided as part of an annual physical, which is covered at 100%. In some cases, an office visit or facility copayment or coinsurance may apply if the preventive service or item is billed separately from the visit. A copayment or coinsurance may also apply if the primary purpose of your visit is not routine, preventive care. All services must be performed by a provider in your network. This list does not apply to all VIVA HEALTH plans. Please refer to your Certificate of Coverage to determine the terms of your health plan.

| PREVENTIVE SERVICE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | FREQUENCY/LIMITATIONS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Well Baby Visits</b> (Age 0-2)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | <b>As recommended per guidelines<sup>1</sup></b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <ul style="list-style-type: none"> <li>Routine screenings, tests, and immunizations</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                | As recommended per guidelines                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Well Child Visits</b> (Age 3-17)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | <b>One per year at PCP<sup>2</sup></b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <ul style="list-style-type: none"> <li>Routine screenings, tests, &amp; immunizations</li> <li>HIV screening and counseling</li> <li>Obesity screening</li> <li>Hepatitis B virus screening</li> <li>Sexually transmitted infection counseling</li> <li>Anxiety and depression screening</li> <li>Skin cancer behavioral counseling</li> </ul>                                                                                                                                                                                                | As recommended per guidelines<br>As recommended per guidelines<br>As recommended per guidelines<br>As recommended per guidelines<br>Annually<br>Ages 8 and above; Up to three each per calendar year<br>Ages 10 and above; As recommended per guidelines                                                                                                                                                                                                                                                                                                                               |
| <b>Routine Physical</b> (Age 18+; <i>Must be part of your annual physical or OB/GYN visit for coverage at 100%</i> )                                                                                                                                                                                                                                                                                                                                                                                                                          | <b>One per year at PCP<sup>2</sup></b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <ul style="list-style-type: none"> <li>Alcohol misuse screening and counseling</li> <li>Anxiety and depression screening</li> <li>Blood pressure screening</li> <li>Cholesterol screening</li> <li>Diabetes screening</li> <li>Hepatitis B and C virus screening</li> <li>HIV screening and counseling</li> <li>Obesity screening</li> <li>Sexually transmitted infection counseling</li> <li>Syphilis screening</li> <li>Skin cancer behavioral counseling (Up to age 24)</li> </ul>                                                         | Annually<br>Up to 3 each per calendar year (incl. screenings at physical & well woman visit)<br>Annually<br>As recommended per guidelines<br>As recommended per guidelines<br>As recommended per guidelines<br>As recommended per guidelines<br>As recommended per guidelines<br>Annually<br>As recommended per guidelines<br>As recommended per guidelines                                                                                                                                                                                                                            |
| <b>Well Woman Visit</b> (Adolescents & Adults; <i>Must be part of your annual physical or OB/GYN visit for coverage at 100%</i> )                                                                                                                                                                                                                                                                                                                                                                                                             | <b>One per year at PCP<sup>2</sup> or OB/GYN</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <ul style="list-style-type: none"> <li>Pap smear/cervical cancer screening</li> <li>Chlamydia screening</li> <li>Contraception counseling</li> <li>Domestic violence screening and counseling</li> <li>Gonorrhea screening</li> <li>HPV DNA testing</li> <li>Anxiety and depression screening</li> </ul>                                                                                                                                                                                                                                      | Annually<br>As recommended per guidelines<br>As recommended per guidelines<br>Annually<br>As recommended per guidelines<br>Females 30+, every three years<br>Up to 3 each per calendar year (incl. screenings at physical & well woman visit)                                                                                                                                                                                                                                                                                                                                          |
| <b>Maternity Care</b> (Pregnant Individuals) Up to 6 visits per pregnancy for the following services:                                                                                                                                                                                                                                                                                                                                                                                                                                         | <b>As recommended per guidelines</b> (Prenatal and Postpartum Services)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <ul style="list-style-type: none"> <li>Anemia screening</li> <li>Bacteriuria screening</li> <li>Chlamydia screening</li> <li>Anxiety and depression screening</li> <li>Perinatal depression counseling</li> <li>Gestational diabetes mellitus screening</li> <li>Gonorrhea screening</li> <li>Hepatitis B screening</li> <li>HIV screening</li> <li>Rh incompatibility screening</li> <li>Syphilis screening</li> <li>Breast feeding counseling</li> <li>Tobacco counseling</li> <li>Breast pump purchase and supplies<sup>3</sup></li> </ul> | As recommended per guidelines<br>One at 12-16 weeks' gestation<br>One per pregnancy if at-risk<br>One each per pregnancy and after delivery<br>Two per year<br>First prenatal visit if high-risk; after 24 weeks of gestation for all others<br>One per pregnancy if at-risk<br>First prenatal visit<br>One per pregnancy<br>First prenatal visit; repeated testing at 24-28 weeks' gestation if at-risk<br>One per pregnancy<br>Five per pregnancy<br>Three per pregnancy for individuals who smoke<br>Breast pump limited to one electric pump selected by VIVA HEALTH per pregnancy |
| <b>Contraception</b> (Females)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <ul style="list-style-type: none"> <li>Implant (Implanon)</li> <li>Injection (Depo-Provera shot)</li> <li>I.U.D.</li> <li>Diaphragm or cervical cap</li> <li>Sterilization</li> <li>Oral Contraceptives</li> </ul>                                                                                                                                                                                                                                                                                                                            | As recommended per guidelines; Performed in physician's office<br>One every three months<br>As recommended per guidelines; Performed in physician's office<br>One Per Year<br>One procedure per lifetime<br>Consult Proxys/MedOne for details, frequency, and limitations.                                                                                                                                                                                                                                                                                                             |



# Wellness Benefits



## PREVENTIVE SERVICE

## FREQUENCY/LIMITATIONS

### Contraception (Females) *continued*

- |                                             |                                                                |
|---------------------------------------------|----------------------------------------------------------------|
| • Over the counter contraceptives (Females) | Consult Proxys/MedOne for details, frequency, and limitations. |
| • Contraceptive patch                       | Consult Proxys/MedOne for details, frequency, and limitations. |
| • Contraceptive vaginal ring                | Consult Proxys/MedOne for details, frequency, and limitations. |

### OTHER PREVENTIVE SERVICES

### FREQUENCY/LIMITATIONS

- |                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                     |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| • <b>Osteoporosis screening</b> (All females age 65+ and at-risk of all ages)                                                                                                                                                                                                                            | As recommended per guidelines                                                                                                                                       |
| • <b>Screening mammography</b> (Females age 40+)                                                                                                                                                                                                                                                         | One per year                                                                                                                                                        |
| • <b>BRCA risk assessment and genetic counseling/testing</b> (At-risk Females)                                                                                                                                                                                                                           | Per medical/family history                                                                                                                                          |
| • <b>Lung cancer screening</b> (Very heavy smokers age 50-80)                                                                                                                                                                                                                                            | One per year, as recommended per guidelines                                                                                                                         |
| • <b>Colorectal cancer screening</b> (Age 45+)                                                                                                                                                                                                                                                           |                                                                                                                                                                     |
| o Fecal occult blood testing and Fecal Immunochemical Test (FIT)                                                                                                                                                                                                                                         | One per year                                                                                                                                                        |
| o Fecal-DNA                                                                                                                                                                                                                                                                                              | One every three years                                                                                                                                               |
| o Sigmoidoscopy                                                                                                                                                                                                                                                                                          | One every five years                                                                                                                                                |
| o Screening colonoscopy                                                                                                                                                                                                                                                                                  | One every 10 years                                                                                                                                                  |
| • <b>Abdominal aortic aneurysm screening</b> (Males age 65-75 w/ smoking history)                                                                                                                                                                                                                        | One per lifetime                                                                                                                                                    |
| • <b>Tuberculosis screening</b> (Asymptomatic, at-risk adults age 18+)                                                                                                                                                                                                                                   | One per year, as recommended per guidelines                                                                                                                         |
| • <b>Dental caries prevention</b> (Infants and children from birth through age 5)                                                                                                                                                                                                                        | Four per year at physician's office                                                                                                                                 |
| • <b>Routine immunizations<sup>4</sup></b> (not travel related)                                                                                                                                                                                                                                          | As recommended by CDC                                                                                                                                               |
| Includes, but not limited to:                                                                                                                                                                                                                                                                            |                                                                                                                                                                     |
| o Influenza (Age 6 months-adult)                                                                                                                                                                                                                                                                         | Two per calendar year                                                                                                                                               |
| o HPV (Starting age 11-12 or catch-up ages 27-45)                                                                                                                                                                                                                                                        | Three doses per lifetime                                                                                                                                            |
| o Pneumococcal                                                                                                                                                                                                                                                                                           | As recommended by PCP                                                                                                                                               |
| o RSV                                                                                                                                                                                                                                                                                                    | Infants <8 months, children 8 months – 19 months at increased risk of severe RSV, pregnant individuals 32-36 weeks gestational age of pregnancy, and adults age 60+ |
| o COVID                                                                                                                                                                                                                                                                                                  | As recommended by CDC                                                                                                                                               |
| o Zoster (Shingles) (Age 60+)                                                                                                                                                                                                                                                                            | One per lifetime                                                                                                                                                    |
| o RZV/Shingrix (Shingles) (Age 50+)                                                                                                                                                                                                                                                                      | Two doses per lifetime                                                                                                                                              |
| • <b>Diet/nutrition counseling</b>                                                                                                                                                                                                                                                                       | Three visits per year                                                                                                                                               |
| • <b>Obesity counseling</b> (Clinically obese children: BMI ≥ 95 <sup>th</sup> percentile for age and sex; Clinically obese adults: BMI ≥ 30)                                                                                                                                                            | Six visits per lifetime                                                                                                                                             |
| • <b>Tobacco use counseling and interventions</b>                                                                                                                                                                                                                                                        | Two visits per year with PCP or specialist                                                                                                                          |
| • <b>HIV Preventive Services</b> (HIV-uninfected people at high risk, when testing for or undergoing pre-exposure preventive therapy (PrEP). Services include HIV testing, Hepatitis B and C testing, creatine testing, pregnancy testing, STI screening and counseling, and PrEP adherence counseling.) | HIV testing every three months; Other services as recommended per guidelines                                                                                        |

### PHARMACY BENEFITS - Consult Proxys/MedOne for details, frequency, and limitations

- |                                                    |                                                   |
|----------------------------------------------------|---------------------------------------------------|
| • Aspirin to prevent heart disease                 | • Over the counter contraceptives                 |
| • Low-dose (81 mg) aspirin to prevent preeclampsia | • Oral fluoride supplements                       |
| • Folic acid supplements                           | • Tobacco cessation products                      |
| • Iron supplements                                 | • Breast cancer preventive drugs                  |
| • Oral contraceptives                              | • Statins to prevent cardiovascular disease (CVD) |
| • HIV pre-exposure preventive (PrEP) therapy       |                                                   |

<sup>1</sup>“As recommended per guidelines” means as recommended by your physician and in accordance with guidelines issued under the Affordable Care Act. <sup>2</sup>PCP means personal care provider or primary care physician and is generally an internist, family practitioner, general practitioner, pediatrician, and sometimes an obstetrician/gynecologist. <sup>3</sup>To order a breast pump or breast pump supplies, member must be within 30 days of due date or actively breastfeeding. Call MedSouth Medical Supplies at 1-800-423-8677. Exceptions to limits may apply based on medical necessity. <sup>4</sup>For a full list of covered immunizations, please visit [www.vivahealth.com](http://www.vivahealth.com) or call VIVA HEALTH Customer Service at 1-800-294-7780 and ask a representative to mail you a copy.



# Did you know? You have Teladoc



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Set up your account by web, phone or mobile app.

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A doctor will review your medical history and contact you in minutes.



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# Finding a provider is *easy*.

Following the instructions below you can choose from a large network of a doctors, hospitals, an ancillary providers (a provider who is not a doctor, like a DME supplier or dialysis center), or an urgent care facility.



**STEP 1:** Visit VivaHealth.com and select "Find a doctor."

**STEP 2:** Select that you are a Commercial Member.

I am a Medicare Member

I am a Commercial Member

**STEP 3:** Select the type of search.

Provider Search

Ancillary Provider Search

Hospital Search

Urgent Care Search

**STEP 4:** Fill in your necessary information. You can also narrow down your search by specialty, network, and location.

**STEP 5:** Your search results will then be produced. Results will include provider name, address, and phone number.

## How can we help you today?

-  Find a doctor >
-  Find prescription drugs >
-  Download our App >
-  Shop for Medicare plans >

Search

Your Location

Distance

Sort By

Networks

Provider Types

Specialties

Counties

Language

Results per Page

☐ Show only providers accepting new patients

Search

Basic

Clear

If you have any questions about VIVA HEALTH's provider network or online provider search, please call VIVA HEALTH Customer Service at 1-800-294-7780, Monday – Friday, 8 am – 5 pm. We are here to help.





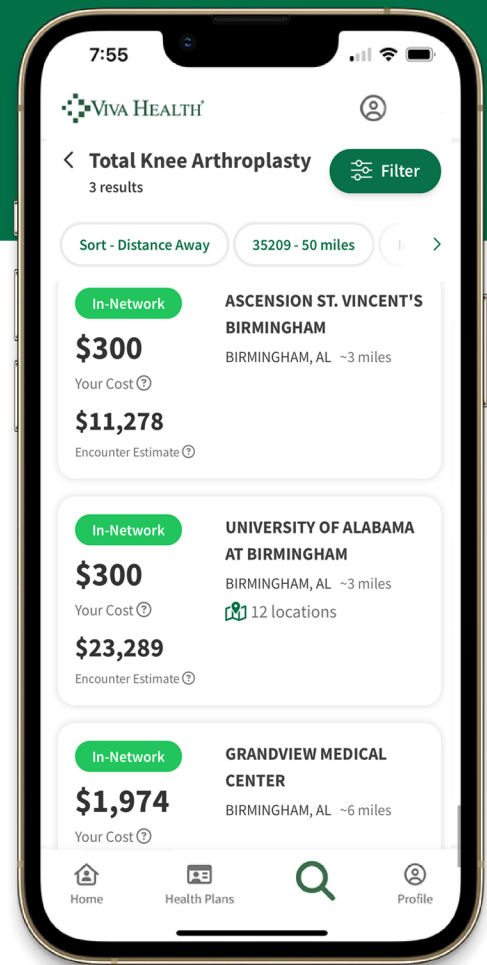
# MyMedicalShopper™ Healthcare Price Comparison Tool

## What is this?

MyMedicalShopper™ is a powerful tool that makes shopping for your medical care easy. Our tool empowers you to choose where to receive medical care based on price, quality, and convenience – the same way you might shop for everything else in your life.

## Use MyMedicalShopper™ to:

- ✓ Find providers and services
- ✓ Know before you go: get estimates for procedures and care
- ✓ Save and Compare healthcare prices



Your employer has provided you with this valuable benefit to help you minimize your out-of-pocket costs and save money!



|                            | Comprehensive Metabolic Panel | MRI of Lower Joint | Nuclear Stress Test |
|----------------------------|-------------------------------|--------------------|---------------------|
| Lowest Price Paid          | \$22                          | \$385              | \$1,146             |
| Highest Price Paid         | \$604                         | \$3,313            | \$6,074             |
| You Can Save               | \$572                         | \$2,928            | \$4,928             |
| Distance Between Providers | 10 Miles                      | 13 Miles           | 25 Miles            |

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Use MyMedicalShopper™  
to help save money on your healthcare expenses.

Activate your account by registering at [mymedicalshopper.com/wl/viva-health](https://mymedicalshopper.com/wl/viva-health).  
Your Member ID# is your Family ID# plus ID Suffix on your medical insurance card.

Download the TALON Health app to use MyMedicalShopper™ today!







# Remember:

**Emergency and urgent care coverage is available worldwide.**

If you are outside the service area and have an urgent and unforeseen need for care that can't wait until you return home, you are covered. This includes care in a physician's office for an unexpected illness or injury that would not be classified as an emergency, but does require immediate attention. Care in an emergency room is only covered for treatment of emergency medical conditions. Of course, this does not include routine or elective medical services, and you must return to the service area for any follow-up care. Still, if you're on a weekend trip or extended vacation, you can relax knowing that you are covered.

## Do you have any questions?

Local customer service representatives are available to help you Monday through Friday from 8AM to 5PM at (205) 558-7474, toll-free at (800) 294-7780 (TTY 711), and by email at [VivaMemberHelp@uabmc.edu](mailto:VivaMemberHelp@uabmc.edu).

You can also download the VIVA HEALTH Mobile App to view your claims status, view a digital ID card, and request electronic EOBs.



A Member of the **UAB** Health System

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