



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

<https://www.vivahealth.com/Group/Login>. 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](http://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 <a href="#">deductible</a> ?	\$250/individual or \$750/family (Tier 1); \$1,000/individual or \$2,000/family (Tier 2)	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> , benefits with a <a href="#">copayment</a> , and benefits where it is indicated that the <a href="#">deductible</a> does not apply.	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$4,000/individual or \$8,000/family (Tier 1); \$7,500/individual or \$15,000/family (Tier 2). For maternity hospitalization: \$1,500 per calendar year.	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance-billed</a> charges, health care this <a href="#">plan</a> doesn't cover, and out-of-network expenses for non-emergency and non-urgent services. Certain <a href="#">Specialty Drugs</a> are considered non-essential health benefits and are not applied to the <a href="#">out-of-pocket limit</a> . The cost of these drugs (reimbursed by the manufacturer at no cost to you) will not be applied toward satisfying your <a href="#">out-of-pocket limit</a> .	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.myvivaprovider.com">www.myvivaprovider.com</a> or call 1-800-294-7780 for a list of <a href="#">network providers</a> .	You pay the least if you use a <a href="#">provider</a> in Tier 1. You pay more if you use a <a href="#">provider</a> in Tier 2. You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .



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 <a href="#">provider's office or clinic</a>	Primary care visit to treat an injury or illness	\$30 <a href="#">copay</a> /visit (Tier 1); \$50 <a href="#">copay</a> /visit (Tier 2)	Not covered	<a href="#">Deductible</a> does not apply.
	<a href="#">Specialist</a> visit	\$50 <a href="#">copay</a> /visit (Tier 1); \$60 <a href="#">copay</a> /visit (Tier 2)	Not covered	OB/GYN: No charge for visit at Tier 1. Chiropractor: \$30 <a href="#">copay</a> per visit (Tiers 1 and 2). Medical Nutritionist counseling limited to 6 visits per Calendar Year with a Nutritionist or Registered Dietitian. <a href="#">Deductible</a> does not apply.
	<a href="#">Preventive care/screening/immunization</a>	No charge	Not covered	<a href="#">Deductible</a> does not apply. 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 <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	X-Rays: \$30 <a href="#">copay</a> /visit (Tier 1), 40% <a href="#">coinsurance</a> (Tier 2); laboratory tests: 100% coverage (Tiers 1 and 2)	Not covered	Office visit or facility <a href="#">copay</a> may apply. Covered genetic testing subject to 20% <a href="#">coinsurance</a> (Tier 1) and 40% <a href="#">coinsurance</a> (Tier 2) and requires prior authorization. If <a href="#">prior authorization</a> is not obtained, no charges for those services will be covered by the <a href="#">plan</a> . <a href="#">Deductible</a> does not apply to laboratory tests (any tier) or Tier 1 x-rays.
	Imaging (CT/PET scans, MRIs)	\$30 <a href="#">copay</a> /visit(Tier 1); 40% <a href="#">coinsurance</a> (Tier 2)	Not covered	Certain imaging tests require <a href="#">prior authorization</a> for <a href="#">plan</a> to pay for them. See <a href="#">plan</a> documents for more information. If <a href="#">prior authorization</a> is not obtained, no charges for those services will be covered by the <a href="#">plan</a> . <a href="#">Deductible</a> does not apply to Tier 1 imaging.
If you need drugs to treat your illness or condition  More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.vivahealth.com">www.vivahealth.com</a>	Generic drugs	\$10 <a href="#">copay</a> /prescription (30 days) or \$20 <a href="#">copay</a> /prescription (90 days) at St. Vincent's Hospital; \$20 <a href="#">copay</a> /prescription (per 30-days) at ESI retail; \$40 <a href="#">copay</a> /prescription (90-day mail order)	Not covered	<a href="#">Deductible</a> does not apply. Covers up to a 30-day supply (ESI retail) or 90-day supply (St. Vincent's Hospital or mail order). No charge for generic and select brand oral contraceptive drugs.
	Preferred brand drugs	\$25 <a href="#">copay</a> /prescription (per 30-days at St.	Not covered	<a href="#">Deductible</a> does not apply. Covers up to a 30-day supply (ESI retail) or 90-day supply (mail order). If generic is

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.vivahealth.com/Group/Login](http://www.vivahealth.com/Group/Login)

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)	
		Vincent's Hospital); \$50 <a href="#">copay</a> /prescription (per 30-days ESI retail); \$100 <a href="#">copay</a> /prescription (90-day mail order)		available, you pay the difference between the generic and brand price, plus the <a href="#">copay</a> . No charge for select brand oral contraceptive drugs.
	Non-preferred brand drugs	\$75 <a href="#">copay</a> /prescription (per 30 days at St. Vincent's Hospital or ESI retail); \$150 <a href="#">copay</a> /prescription (90- day mail order)	Not covered	<a href="#">Deductible</a> does not apply. Covers up to a 30-day supply (ESI retail) or 90-day supply (mail order). If generic is available, you pay the difference between the generic and brand price, plus the <a href="#">copay</a> . No charge for select brand oral contraceptive drugs.
	Specialty Drugs	\$200 <a href="#">copay</a> /prescription (preferred drugs); \$350 <a href="#">copay</a> /prescription (non-preferred drugs)	Not covered	<a href="#">Deductible</a> does not apply. Requires <a href="#">prior authorization</a> for <a href="#">plan</a> to pay for drugs. Call 1-800-803-2523. If <a href="#">prior authorization</a> is not obtained, no charges for those services will be covered by the <a href="#">plan</a> . <a href="#">Copay</a> for certain <a href="#">Specialty Drugs</a> may vary and be set to the maximum of any available manufacturer-funded <a href="#">copay</a> assistance programs. Benefits for some Specialty Drugs will be coordinated through the SaveOn program. Please see "Important Questions" regarding the plan's <a href="#">out-of-pocket limit</a> .
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$150 <a href="#">copay</a> /visit (Tier 1); 40% <a href="#">coinsurance</a> (Tier 2)	Not covered	Requires <a href="#">prior authorization</a> for <a href="#">plan</a> to pay for outpatient surgery. If <a href="#">prior authorization</a> is not obtained, no charges for those services will be covered by the <a href="#">plan</a> . <a href="#">Deductible</a> does not apply to Tier 1.
	Physician/surgeon fees	\$0 <a href="#">copay</a> / admission (Tier 1); 40% <a href="#">coinsurance</a> (Tier 2)	Not covered	Requires <a href="#">prior authorization</a> for <a href="#">plan</a> to pay for outpatient surgery. If <a href="#">prior authorization</a> is not obtained, no charges for those services will be covered by the <a href="#">plan</a> . <a href="#">Deductible</a> does not apply to Tier 1.
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$250 <a href="#">copay</a> /visit (Tiers 1 and 2)	Not covered	<a href="#">Deductible</a> does not apply. Limited to <a href="#">emergency medical conditions</a> . Follow-up care is not covered. See <a href="#">plan</a> documents for more information.
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a> (Tiers 1 and 2)	Not covered	Limited to transportation to a hospital.
	<a href="#">Urgent care</a>	\$30 <a href="#">copay</a> /visit (Tier 1); \$50 <a href="#">copay</a> /visit (Tier 2)	\$50 <a href="#">copay</a> /visit	<a href="#">Deductible</a> does not apply. Coverage from non-participating providers is limited to urgently-needed services provided at an <a href="#">urgent care</a> facility.

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.vivahealth.com/Group/Login](http://www.vivahealth.com/Group/Login)

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 have a hospital stay	Facility fee (e.g., hospital room)	\$300 <a href="#">copay</a> /admission (Tier 1); 40% <a href="#">coinsurance</a> (Tier 2)	Not covered except for <a href="#">emergency medical conditions</a>	Requires <a href="#">prior authorization</a> for <a href="#">plan</a> to pay for admission except for <a href="#">emergency medical conditions</a> . If <a href="#">prior authorization</a> is not obtained, no charges for those services will be covered by the <a href="#">plan</a> . <a href="#">Deductible</a> does not apply to Tier 1.
	Physician/surgeon fees	\$0 <a href="#">copay</a> /admission (Tier 1); 40% <a href="#">coinsurance</a> (Tier 2)	Not covered except for <a href="#">emergency medical conditions</a>	Requires <a href="#">prior authorization</a> for <a href="#">plan</a> to pay for admission except for <a href="#">emergency medical conditions</a> . If <a href="#">prior authorization</a> is not obtained, no charges for those services will be covered by the <a href="#">plan</a> . <a href="#">Deductible</a> does not apply to Tier 1.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$30 <a href="#">copay</a> /visit (Tiers 1 and 2)	Not covered	<a href="#">Deductible</a> does not apply. Partial Hospitalization and Intensive Outpatient Program services require <a href="#">prior authorization</a> for <a href="#">plan</a> to pay for admission. If <a href="#">prior authorization</a> is not obtained, no charges for those services will be covered by the <a href="#">plan</a> .
	Inpatient services	\$200 <a href="#">copay</a> /admission (Tier 1); 20% <a href="#">coinsurance</a> (Tier 2)	Not covered except for <a href="#">emergency medical conditions</a>	Requires <a href="#">prior authorization</a> for <a href="#">plan</a> to pay for admission. If <a href="#">prior authorization</a> is not obtained, no charges for those services will be covered by the <a href="#">plan</a> . <a href="#">Deductible</a> does not apply to Tier 1.
If you are pregnant	Office visits	\$0 <a href="#">copay</a> /delivery (Tier 1); \$60 <a href="#">copay</a> /delivery (Tier 2)	Not covered	No coverage for surrogate pregnancy. <a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Maternity care may include tests and services described elsewhere in the SBC. See <a href="#">plan</a> documents for more information. <a href="#">Out-of-pocket limit</a> for maternity hospitalization is \$1,500 per calendar year. <a href="#">Deductible</a> does not apply to office visits or Tier 1 professional and facility services.
	Childbirth/delivery professional services	\$0 <a href="#">copay</a> /admission (Tier 1); 40% <a href="#">coinsurance</a> (Tier 2)	Not covered	
	Childbirth/delivery facility services	\$300 <a href="#">copay</a> /admission (Tier 1); 40% <a href="#">coinsurance</a> (Tier 2)	Not covered	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a> (Tiers 1 and 2)	Not covered	Requires <a href="#">prior authorization</a> for <a href="#">plan</a> to pay for care. If <a href="#">prior authorization</a> is not obtained, no charges for those services will be covered by the <a href="#">plan</a> . Limited to 60 visits per calendar year. <a href="#">Deductible</a> does not apply to Tier 1 for home health services but does for home infusion services.
	<a href="#">Rehabilitation services</a>	\$30 <a href="#">copay</a> /visit (Tiers 1 and 2)	Not covered	Requires <a href="#">prior authorization</a> for <a href="#">plan</a> to pay for therapy. If <a href="#">prior authorization</a> is not obtained, no charges for those services will be covered by the <a href="#">plan</a> . <a href="#">Deductible</a> does not apply.

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.vivahealth.com/Group/Login](http://www.vivahealth.com/Group/Login)

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)	
	<a href="#">Habilitation services</a>	\$30 <a href="#">copay</a> /visit (Tiers 1 and 2)	Not covered	Requires <a href="#">prior authorization</a> for <a href="#">plan</a> to pay for therapy. If <a href="#">prior authorization</a> is not obtained, no charges for those services will be covered by the <a href="#">plan</a> . <a href="#">Deductible</a> does not apply.
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a> (Tiers 1 and 2)	Not covered	Requires <a href="#">prior authorization</a> for <a href="#">plan</a> to pay for care. If <a href="#">prior authorization</a> is not obtained, no charges for those services will be covered by the <a href="#">plan</a> . Limited to 100 days per lifetime.
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a> (Tiers 1 and 2)	Not covered	Requires <a href="#">prior authorization</a> for <a href="#">plan</a> to pay for service. If <a href="#">prior authorization</a> is not obtained, no charges for those services will be covered by the <a href="#">plan</a> .
	<a href="#">Hospice services</a>	20% <a href="#">coinsurance</a> (Tiers 1 and 2)	Not covered	Requires <a href="#">prior authorization</a> for <a href="#">plan</a> to pay for service. If <a href="#">prior authorization</a> is not obtained, no charges for those services will be covered by the <a href="#">plan</a> . <a href="#">Deductible</a> does not apply to Tier 1.
If your child needs dental or eye care	Children's eye exam	\$50 <a href="#">copay</a> /visit (Tiers 1 and 2)	Not covered	Limited to one routine visit per calendar year and medically necessary visits for illness or injury. <a href="#">Deductible</a> does not apply.
	Children's glasses	Not covered	Not covered	<a href="#">Excluded service</a> .
	Children's dental check-up	Not covered	Not covered	<a href="#">Excluded service</a> .

### 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"> <li>• Acupuncture</li> <li>• Cosmetic surgery (except reconstructive surgery necessary to repair a functional disorder from disease, injury, or congenital anomaly)</li> </ul> | <ul style="list-style-type: none"> <li>• Dental care (Adult and Child)</li> <li>• Hearing aids</li> <li>• Infertility treatment</li> <li>• Long-term care</li> </ul> | <ul style="list-style-type: none"> <li>• Non-emergency care when traveling outside the U.S.</li> <li>• Private-duty nursing</li> <li>• Weight loss programs</li> </ul> |
|---|--|--|

#### 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"> <li>• Bariatric surgery</li> <li>• Chiropractic care</li> </ul> | <ul style="list-style-type: none"> <li>• Routine eye care</li> </ul> | <ul style="list-style-type: none"> <li>• Routine foot care (Diabetics only)</li> </ul> |
|--|--|--|

**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.cms.gov](http://www.cciio.cms.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](http://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.

**Does this plan provide Minimum Essential Coverage? Yes**

[Minimum Essential Coverage](#) generally includes [plans](#), health insurance available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

**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](#).

**Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-294-7780 (TTY: 711).

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-294-7780 (TTY: 711).

*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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$250
■ <a href="#">Specialist copayment</a>	\$0
■ Hospital (facility) <a href="#">copayment</a>	\$300
■ Other <a href="#">cost-sharing</a>	\$0/0%

#### 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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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#### In this example, Peg would pay:

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

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$250
■ <a href="#">Specialist copayment</a>	\$50
■ Hospital (facility) <a href="#">copayment</a>	\$300
■ Other <a href="#">cost-sharing</a>	\$0/20%

#### 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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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#### In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$800
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$820</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$250
■ <a href="#">Specialist copayment</a>	\$50
■ Hospital (facility) <a href="#">copayment</a>	\$300
■ Other <a href="#">cost-sharing</a>	\$30/\$250/20%

#### This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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#### In this example, Mia would pay:

Cost Sharing	
Deductibles	\$250
Copayments	\$600
Coinsurance	\$200
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,050</b>

Note: These numbers assume the patient received services from UAB St. Vincent's plan Tier 1 network hospital. If you receive services from a different hospital, your costs may be higher.