VIVA HEALTH®

UAB ACCESS

Effective Dates: January 1, 2016 – December 31, 2016

Attachment A to Certificate of Coverage

The Plan's services and benefits, with their copayments, coinsurance, and some of the limitations, are listed below. Please remember that this is only a brief listing. For further information, plan guidelines, and exclusions, please see the Certificate of Coverage.

Please keep this Attachment A for your records.

BENEFITS	COVERAGE (Tier 1) UAB Network*	COVERAGE (Tier 2) VIVA HEALTH Network*
CALENDAR YEAR OUT-OF-POCKET MAXIMUM: The most a Member will pay per Calendar Year for qualified medical, mental, and substance abuse services, prescription drugs, and specialty drugs. The maximum includes deductibles, copayments, and coinsurance paid by the Member for qualified services but does not include premiums or out-of-network charges over the maximum payment allowance. See the Certificate of Coverage for details.	$6,850 per individual; $13,700 per family	
PREVENTIVE CARE: • **Well Baby Care** (Children under age 3) • **Routine Physicals** (One per Calendar Year for ages 3+) • **Covered Immunizations** • **Preventive Prenatal Care** (As defined in the Certificate of Coverage) • **OB/GYN Preventive Visit** (One per Calendar Year) • **Other preventive items and services. See Certificate of Coverage for recommendations and guidelines.**	100% Coverage	100% Coverage
OTHER PRIMARY CARE SERVICES: • **Medical Physician Services** • **Illness and Injury** • **Hearing Exams** • **X-Ray and Laboratory Procedures** ○ Covered Genetic Testing	$15 Copayment per visit 80% Coverage	$20 Copayment per visit 80% Coverage
SPECIALTY CARE: *(No PCP Referral Required)* • **Medical Physician Services** • **Illness and Injury** • **OB/GYN Services** • **X-Ray and Laboratory Procedures** ○ Covered Genetic Testing	$30 Copayment per visit 80% Coverage	$40 Copayment per visit 80% Coverage
URGENT CARE CENTER SERVICES: • **Medical Physician Services** • **Illness and Injury**	$30 Copayment per visit	$40 Copayment per visit
VISION CARE: *(No PCP Referral Required)* • **One routine vision exam per Calendar Year** • **Other eye care office visits**	$30 Copayment per visit $30 Copayment per visit	$30 Copayment per visit $30 Copayment per visit
ALLERGY SERVICES: *(No PCP Referral Required)* • **Physician Services** • **Testing**	$30 Copayment per visit 80% Coverage	$40 Copayment per visit 80% Coverage
DIAGNOSTIC SERVICES: *(Including but not limited to CT Scan, MRI, PET/SPECT, ERCP)*	$100 Copayment per service	$200 Copayment per service
OUTPATIENT SERVICES: • **Surgery and Other Outpatient Services**	$150 Copayment per visit	$250 Copayment per visit
HOSPITAL INPATIENT SERVICES: • **Physician Services** • **Semi-Private Room**	100% Coverage $250 Copayment per admission	100% Coverage $250 Copayment per day (Days 1-5)
MATERNITY SERVICES: *(Covered for employee and employee's spouse; not covered for dependent children except as provided under Preventive Care)* • **Physician Services** *(Prenatal, delivery, and postnatal care)* • **Maternity Hospitalization** **Eligible baby must be enrolled in plan within 30 days of birth or adoption for baby's care to be covered.**	$30 Copayment per delivery $250 Copayment per admission	$40 Copayment per delivery $250 Copayment per day (Days 1-5)
EMERGENCY ROOM SERVICES:	$100 Copayment per visit (waived if admitted within 24 hours)	$200 Copayment per visit (waived if admitted within 24 hours)
EMERGENCY AMBULANCE SERVICES: *(Must be Medically Necessary)*	80% Coverage	80% Coverage
DURABLE MEDICAL EQUIPMENT AND PROSTHETIC DEVICES:	80% Coverage	80% Coverage
SKILLED NURSING FACILITY SERVICES: *(Limited to 60 days per Calendar Year)*	80% Coverage	80% Coverage
DIABETIC SUPPLIES: Insulin covered under CAREMARK prescription plan. For Diabetic Supplies call VIVA HEALTH.	100% Coverage	100% Coverage
REHABILITIATION SERVICES: Physical, Speech, and Occupational Therapy	$30 Copayment per visit; $250 Copayment per admission	$40 Copayment per visit; $250 Copayment per day (Days 1-5)
HOME HEALTH CARE SERVICES: *(Limited to 60 visits per Calendar Year)*	80% Coverage	80% Coverage

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BENEFITS	COVERAGE (Tier 1) UAB Network*	COVERAGE (Tier 2) VIVA HEALTH Network*
CHIROPRACTIC SERVICES: *(No PCP Referral Required)* • **Treatment for manual manipulation of subluxations only**	$40 Copayment per visit	
TEMPOROMANDIBULAR JOINT DISORDER: *($3,500 maximum benefit per Lifetime)*	$30 Copayment per visit	$40 Copayment per visit
SLEEP DISORDERS: *(2 Sleep Studies per Member per Lifetime)*	$30 Copayment per visit; $150 Copayment per service	$40 Copayment per visit; $250 Copayment per service
TRANSPLANT SERVICES:	100% Coverage after $250 Hospital Copayment	100% Coverage after $250 Copayment per day (Days 1-5)
MENTAL HEALTH & SUBSTANCE ABUSE SERVICES[1]: • **Inpatient Services** • **Outpatient Services** [1]Residential treatment and certain diagnoses are excluded. See your Certificate of Coverage for details.	100% Coverage after $250 Copayment per admission $30 Copayment per visit	100% Coverage after $250 Copayment per day (Days 1-5) $40 Copayment per visit
PHARMACY DEDUCTIBLE: Applies to all drugs except for generic oral contraceptives and other preventive drugs required by the Affordable Care Act.	$100 per individual; $200 aggregate amount per family	
COVERED PRESCRIPTION DRUGS[2]:		
• **Generic Drugs**		
○ From a Participating Pharmacy	$15 Copayment per 31-day supply	
○ Mail-order	$30 Copayment per 90-day supply	
○ Participating Pharmacy	$45 Copayment per 90-day supply	
• **Preferred Brand Drugs**		
○ From a Participating Pharmacy	$35 Copayment per 31-day supply	
○ Mail-order	$88 Copayment per 90-day supply	
○ Participating Pharmacy	$105 Copayment per 90-day supply	
• **Non-Preferred Brand Drugs**		
○ From a Participating Pharmacy	$60 Copayment per 31-day supply	
○ Mail-order	$150 Copayment per 90-day supply	
○ Participating Pharmacy	$180 Copayment per 90-day supply	
• **Oral Contraceptives**	$0 Copayment for generic drugs; Applicable Copayment for brand-name drugs	
• **Biological Drugs, Biotechnical Drugs, and Specialty Pharmaceuticals[3]**	80% Coverage	
[2]Some medications may require prior authorization from VIVA HEALTH. For further information, please contact Customer Service at the phone number listed below. [3]May be administered in the home, physician's office or on an outpatient basis. When these medications are received from CAREMARK, they must be ordered by calling 1-800-237-2767. For a list of medications in this category, please refer to http://www.vivaemployer.com/Members/Default.aspx. **When generic is available, Member pays difference between generic and Brand Name price, plus Copayment.** **Check with your participating pharmacy to learn if it is eligible to offer a 90-day supply at retail.**		
SMOKING CESSATION PRODUCTS: **Two, 12-week treatment courses total per Calendar Year. Prescription required.** [Generic nicotine replacement products (including the patch, lozenge, gum, inhaler, or nasal spray), or Nicotrol (inhaler), or Nicotrol NS (nasal spray), or Generic Zyban, or Varenicline tartrate (Chantix).]	$0 Copayment	
DEPENDENT STUDENT BENEFITS: (Emergencies and in-area care are covered under the appropriate sections set forth in the Certificate of Coverage.)	Services to treat an illness or injury for Covered Dependents will be covered while they are full-time students at an accredited educational institution out of the Service Area, subject to the Copayments described herein and a $1,500 maximum benefit per Calendar Year.	
SABBATICAL: (Sabbatical leave is a period of paid leave granted to faculty members by the Employer to pursue professional development, a program of investigation, creative writing, or artistry, and the like.)	Services to treat an illness or injury for Subscribers and Covered Dependents on Sabbatical Leave will be covered while they are out of the Service Area, subject to the Copayments described herein and a $1,500 maximum benefit per Calendar Year.	

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

Eligible Dependent: To be eligible to enroll as a Covered Dependent, a person must be listed on the enrollment application completed by the Subscriber, reside in the Service Area or with the Subscriber (exceptions apply), and meet additional qualifying criteria. For exceptions and additional qualifying criteria, please refer to the Certificate of Coverage.

Pre-Existing Condition Policy: No pre-existing condition exclusions or waiting period.

*Tier 1 coverage applies to all pediatric care for dependents under age 18 regardless of whether those dependents receive their pediatric care in the VIVA HEALTH network or the UAB network. The Tier 2 network includes hospitals and health centers within the VIVA HEALTH network but outside of UAB. UAB means University Hospital, UAB Women and Infants Center, UAB Highlands, The Kirklin Clinic, and all UAB satellite clinics.