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 or call 1-800-294-7780 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes.	You don't have to meet deductibles for specific services, but see the Common Medical Events chart below for other costs for services this plan covers.
Are there other deductibles for specific services?	Yes. $200/individual or $600/family for select Tier 2 non-preventive medical coverage. $150/individual or $300/family for non-preventive prescription drug coverage (excluding weight loss drugs). $200/individual for weight loss drugs. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	$7,500/individual or $15,000/family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, health care this plan doesn't cover, and out-of-network expenses for non-emergency and non-urgent services. Certain specialty drugs are considered non-essential health benefits and are not applied to the out-of-pocket limit. The cost of these drugs (reimbursed by the manufacturer at no cost to you) will not be applied toward satisfying your out-of-pocket limit.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.myvivaprovider.com or call 1-800-294-7780 for a list of network providers.	This plan uses a provider network. You will pay the least if you use a provider in the UAB provider network (Tier 1). You pay more if you use a provider outside the UAB provider network (Tier 2). You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay/visit (Tier 1); $30 copay/visit (Tier 2)	Not covered	Deductible applies to Tier 2 visits.
	Specialist visit	$40 copay/visit (Tier 1); $50 copay/visit (Tier 2)	Not covered	Medical Nutritionist counseling limited to 6 visits per Calendar Year with a Nutritionist or Registered Dietitian. Deductible applies to Tier 2 visits.
	Preventive care/screening/ immunization	No charge	Not covered	Limited to services recommended by federal preventive guidelines. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	Office visit or facility copay may apply. Covered genetic testing subject to 20% coinsurance and requires prior authorization. If prior authorization is not obtained, no charges for those services will be covered by the plan. Deductible does not apply.
	Imaging (CT/PET scans, MRIs)	$100 copay/test (Tier 1); $200 copay/test (Tier 2)	Not covered	Certain imaging tests require prior authorization for plan to pay for them. See plan documents for more information. If prior authorization is not obtained, no charges for those services will be covered by the plan. Deductible applies to Tier 2 services.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.vivahealth.com	Generic drugs	$15 copay/prescription (retail); $30 copay/ prescription (mail order)	Not covered	Covers up to a 30-day supply (retail); 90-day supply (mail order). No charge for generic oral contraceptive drugs. Deductible must be satisfied before copays apply. Deductible applies to all drugs except for generic oral contraceptives and other preventive drugs required by the Affordable Care Act. Weight loss drugs subject to 30% coinsurance after $200 per member weight loss drug deductible except when prescribed for diabetes.
	Preferred brand drugs	$45 copay/prescription (retail); $113 copay/ prescription (mail order)	Not covered	Covers up to a 30-day supply (retail); 90-day supply (mail order). If generic is available, you pay the difference between the generic and brand price, plus the copay. Deductible must be satisfied before copays apply. Weight loss drugs subject to 30% coinsurance and $200 per member weight loss drug deductible except when prescribed for diabetes. No charge for select brand oral contraceptive drugs.

* For more information about limitations and exceptions, see the plan or policy document at 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)	
	Non-preferred brand drugs	$70 copay/prescription (retail); $175 copay/ prescription (mail order)	Not covered	Covers up to a 30-day supply (retail); 90-day supply (mail order). If generic is available, you pay the difference between the generic and brand price, plus the copay. Deductible must be satisfied before copays apply. Weight loss drugs subject to 30% coinsurance and $200 per member weight loss drug deductible except when prescribed for diabetes. No charge for select brand oral contraceptive drugs.
	Specialty drugs	20% coinsurance	Not covered	Requires prior authorization for plan to pay for drugs. Call 1-800-803-2523. If prior authorization is not obtained, no charges for those services will be covered by the plan. Deductible must be satisfied before coinsurance applies. Coinsurance for certain specialty drugs may vary and be set to the maximum of any available manufacturer-funded copay assistance programs. Benefits for some specialty drugs will be coordinated through the SaveOn program. Please see "Important Questions" regarding the plan's out-of-pocket limit.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$150 copay/visit (Tier 1); $250 copay/visit (Tier 2)	Not covered	Requires prior authorization for plan to pay for outpatient surgery. If prior authorization is not obtained, no charges for those services will be covered by the plan. Deductible applies to Tier 2 visits.
	Physician/surgeon fees	No charge	Not covered	Requires prior authorization for plan to pay for outpatient surgery. If prior authorization is not obtained, no charges for those services will be covered by the plan. Deductible does not apply.
If you need immediate medical attention	Emergency room care	$100 copay/visit (Tiers 1 and 2)	$100 copay/visit	Limited to emergency medical conditions. Follow-up care is not covered. See plan documents for more information. Deductible does not apply.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Limited to transportation to a hospital.
	Urgent care	$25 copay/visit at UAB Urgent Care; $40 copay/ visit (Tier 1); $50 copay/ visit (Tier 2)	$50 copay/visit	Coverage from non-participating providers is limited to care outside the VIVA HEALTH service area and requires prior authorization or a referral from a participating provider. If prior authorization or a referral is not obtained, no charges for those services will be covered by the plan. Deductible applies to Tier 2 visits.
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 copay/admission (Tier 1); $250 copay/day (days 1-5) (Tier 2)	Not covered except for emergency medical conditions	Requires prior authorization for plan to pay for admission except for emergency medical conditions. If prior authorization is not obtained, no charges for those services will be covered by the plan. Deductible applies to Tier 2 admissions.

* For more information about limitations and exceptions, see the plan or policy document at 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)	
	Physician/surgeon fees	No charge	Not covered except for emergency medical conditions	Requires prior authorization for plan to pay for admission except for emergency medical conditions. If prior authorization is not obtained, no charges for those services will be covered by the plan. Deductible does not apply.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$40 copay/visit (Tier 1); $50 copay/visit (Tier 2)	Not covered	Partial Hospitalization and Intensive Outpatient Program services require prior authorization for plan to pay for admission. If prior authorization is not obtained, no charges for those services will be covered by the plan. Deductible applies to Tier 2 visits.
	Inpatient services	$250 copay/admission (Tier 1); $250 copay/day (days 1-5) (Tier 2)	Not covered except for emergency medical conditions	Requires prior authorization for plan to pay for admission. If prior authorization is not obtained, no charges for those services will be covered by the plan. Deductible applies to Tier 2 admissions.
If you are pregnant	Office visits	$40 copay/delivery (Tier 1); $50 copay/delivery (Tier 2)	Not covered	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC. See plan documents for more information. Deductible applies to Tier 2 office visits and hospital admission. Deductible does not apply to delivery professional services.
	Childbirth/delivery professional services	No charge	Not covered	
	Childbirth/delivery facility services	$250 copay/admission (Tier 1); $250 copay/day (days 1-5) (Tier 2)	Not covered	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	Not covered	Requires prior authorization for plan to pay for care. If prior authorization is not obtained, no charges for those services will be covered by the plan. Limited to 60 visits per calendar year. Deductible does not apply.
	Rehabilitation services	$40 copay/visit (Tier 1); $50 copay/visit (Tier 2)	Not covered	Requires prior authorization for plan to pay for therapy. If prior authorization is not obtained, no charges for those services will be covered by the plan. Deductible applies to Tier 2 visits.
	Habilitation services	$40 copay/visit (Tier 1); $50 copay/visit (Tier 2)	Not covered	Requires prior authorization for plan to pay for therapy. If prior authorization is not obtained, no charges for those services will be covered by the plan. Deductible applies to Tier 2 visits.
	Skilled nursing care	20% coinsurance	Not covered	Requires prior authorization for plan to pay for care. If prior authorization is not obtained, no charges for those services will be covered by the plan. Limited to 60 days per calendar year. Deductible does not apply.
	Durable medical equipment	20% coinsurance	Not covered	Requires prior authorization for plan to pay for service. If prior authorization is not obtained, no charges for those services will be

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)	
				covered by the plan. Deductible does not apply.
	Hospice services	No charge	Not covered	Requires prior authorization for plan to pay for service. If prior authorization is not obtained, no charges for those services will be covered by the plan. Limited to 180 days per lifetime. Deductible does not apply.
If your child needs dental or eye care	Children's eye exam	$40 copay/visit	Not covered	Limited to one routine visit per calendar year and medically necessary visits for illness or injury. Deductible does not apply.
	Children's glasses	Not covered	Not covered	Excluded service.
	Children's dental check-up	Not covered	Not covered	Excluded service.

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.)

- Acupuncture
- Cosmetic surgery (except reconstructive surgery necessary to repair a functional disorder from disease, injury, or congenital anomaly)
- Dental care (Adult and Child)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery
- Chiropractic care
- Routine eye care
- Infertility treatment
- Routine foot care (Diabetics only)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.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 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**

* For more information about limitations and exceptions, see the plan or policy document at www.vivahealth.com/Group/Login

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.*

* For more information about limitations and exceptions, see the plan or policy document at www.vivahealth.com/Group/Login

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$0
Specialist copayment	$40
Hospital (facility) copayment	$250
Other coinsurance	0%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$10
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$370**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$0
Specialist copayment	$40
Hospital (facility) copayment	$250
Other coinsurance	0%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$150
Copayments	$1,000
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,170**

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

The plan's overall deductible	$0
Specialist copayment	$40
Hospital (facility) copayment	$250
Other cost sharing	20%/$100

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$10
Copayments	$400
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$610**

Note: These numbers assume the patient received services from UAB Hospital. If you receive services from a different hospital, your costs may be higher.

The plan would be responsible for the other costs of these EXAMPLE covered services.