UAB Medicine Enterprise

Effective Dates: January 1, 2025 – December 31, 2025

Attachment A to Certificate of Coverage

The Plan's services and benefits, with their copayments, coinsurance, and some of the limitations, are listed below. **Services received in a primary, specialty, or urgent care office may be subject to a copay or coinsurance in addition to the office visit cost-sharing depending on the type of service received.** Please remember that this is only a brief listing. For further information, please see the Certificate of Coverage. **Please keep this Attachment A for your records.**

MEDICAL BENEFITS	COVERAGE
CALENDAR YEAR OUT-OF-POCKET MAXIMUM: The most a member will pay per Calendar Year for qualified medical, mental, and substance use disorder services, prescription drugs, and specialty drugs. The maximum includes 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. See the Certificate of Coverage for details. Amounts from manufacturer coupons or similar assistance programs used to satisfy Member Copayments or Coinsurance do not count toward the Out-of-Pocket Maximum.	$7,350 per individual; $14,700 per family
PREVENTIVE CARE: • **Well Baby care** (Children under age 3) • **Routine physicals** (One per Calendar Year for 3+) • **Covered immunizations** • **Preventive prenatal care** • **OB/GYN preventive visit** (One per Calendar Year) • **Nutritionist Preventive Visits** (Up to 3 per Calendar Year with a Registered Dietitian or Nutritionist) • **Other preventive items and services** (See Certificate of Coverage for details)	$0 Copayment
OTHER PRIMARY CARE SERVICES:	
• **Medical physician services**	$30 Copayment/visit at UAB; $40 Copayment/visit outside UAB
• **Hearing exams**	$30 Copayment/visit at UAB; $40 Copayment/visit outside UAB
• **Illness and injury**	$30 Copayment/visit at UAB; $40 Copayment/visit outside UAB
• **X-Ray and laboratory procedures**	100% Coverage
○ Covered genetic testing	80% Coverage
SPECIALTY CARE: *(No PCP referral required)*	
• **Medical physician services**	$30 Copayment/visit at UAB; $40 Copayment/visit outside UAB
• **Illness and Injury**	$30 Copayment/visit at UAB; $40 Copayment/visit outside UAB
• **X-Ray and laboratory procedures**	100% Coverage
○ Covered genetic testing	80% Coverage
• **OB/GYN services**	$0 Copayment/visit at UAB; $60 Copayment/visit outside UAB
URGENT CARE CENTER SERVICES:	
• **Medical physician services**	$30 Copayment/visit at UAB; $40 Copayment/visit outside UAB
• **Illness and injury**	
EMERGENCY ROOM SERVICES:	$100 Copayment/visit *(Copayment waived if admitted to hospital)*
EMERGENCY AMBULANCE SERVICES: (Must be Medically Necessary)	80% Coverage
VISION CARE: *(No PCP referral required)* • **Routine vision exam (one per Calendar Year) and other eye care office visits**	$30 Copayment/visit
ALLERGY SERVICES: *(No PCP referral required)*	
• **Physician services**	$30 Copayment/visit
• **Testing**	80% Coverage
DIAGNOSTIC SERVICES: *(Excluding inpatient and ER; including but not limited to CT Scan, MRI, PET/SPECT, ERCP)* *$1,200 out-of-pocket maximum per member per Calendar Year	For CT Scan, MRI and PET only: $100 Copayment/service at UAB, Medical West, or Children's Hospital facilities; $400 Copayment/service outside UAB, Medical West, and Children's Hospital facilities All other diagnostic services: $150 Copayment/service
OUTPATIENT SERVICES:	
• **Surgery and other outpatient services** (non-OB/GYN)	$150 Copayment per service
• **OB/GYN outpatient surgery and other procedures**	$0 Copayment per service at UAB; $250 Copayment/service outside UAB
• **OB/GYN outpatient physician services** (surgical procedures)	$0 Copayment per service at UAB; $150 Copayment/service outside UAB
HOSPITAL INPATIENT SERVICES: Physician and Facility Services	$250 Copayment per admission *(Copayment waived at UAB)*
REHABILITATION AND HABILITATION SERVICES: Physical, Speech, and Occupational Therapy and Applied Behavior Analysis	$30 Copayment/visit
DURABLE MEDICAL EQUIPMENT & PROSTHETIC DEVICES:	80% Coverage
SKILLED NURSING FACILITY SERVICES: (Limited to 100 days per lifetime)	100% Coverage
INFERTILITY SERVICES: *(Subject to a $5,000 maximum family medical benefit per lifetime and a separate $5,000 maximum family prescription drug benefit per Calendar Year. Eligibility limited to subscriber and/or subscriber's spouse.)*	
• **Initial consultation and counseling session**	$0 Copay/visit at UAB; $60 Copay/visit outside UAB; One each/Lifetime
• **Semen analysis, HSG test, and endometrial biopsy**	$0 Copayment; One per Lifetime
• **Medically Necessary office visits and tests** (ultrasound, laboratory tests)	$0 Copayment
• **Prescription drugs**	Cost varies by tier
• **Medical services to treat infertility** [assisted reproductive technology (ART), including intrauterine insemination (IUI) and in vitro fertilization (IVF)]	$0 Copayment/visit at UAB; $150 Copayment/visit outside UAB

UAB means UAB Hospital, UAB Women and Infants Center, UAB Highlands, The Kirklin Clinic of UAB Hospital, UAB Spain Rehabilitation Center, UAB Callahan Eye Hospital, UAB St Vincent's, and all UAB satellite clinics.

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MEDICAL BENEFITS	COVERAGE
MATERNITY SERVICES:	
• **Physician services** (prenatal, delivery, and postnatal care)	$0 Copayment/delivery at UAB; $150 Copayment/delivery outside UAB
• **Hospitalization**	$500 Copayment/admission *(Copayment waived at UAB; $1,500 out-of-pocket maximum per member per Calendar Year)*
Newborn care and other services covered only for enrolled child of employee or employee's spouse. Eligible baby must be enrolled in plan within 30 days of birth or adoption for baby's care to be covered. No coverage for children of employee's dependent child.	
DIABETES SELF-MANAGEMENT EDUCATION:	$30 Copayment per visit at UAB; $40 Copayment/visit outside UAB
DIABETIC SUPPLIES: Insulin covered under prescription drug rider. For Diabetic Supplies call VIVA HEALTH.	100% Coverage
MEDICAL NUTRITION SERVICES: (Limited to 6 visits per Calendar Year with a Registered Dietitian or Nutritionist)	$30 Copayment/visit at UAB; $40 Copayment/visit outside UAB
HOME HEALTH CARE SERVICES: (Limited to 60 visits per Calendar Year)	100% Coverage
CHIROPRACTIC SERVICES: (No PCP Referral Required)	$30 Copayment/visit
TEMPOROMANDIBULAR JOINT DISORDER:	$30 Copayment/visit
SLEEP DISORDERS:	$30 Copayment/visit; $150 Copayment/sleep study
TRANSPLANT SERVICES:	$250 Hospital Copayment *(Copayment waived at UAB)*
MENTAL HEALTH & SUBSTANCE USE DISORDER SERVICES:	
• **Inpatient Services**	$250 Copayment/admission *(Copayment waived at UAB)*
• **Outpatient Services**	$30 Copayment/visit

PHARMACEUTICAL BENEFITS	COVERAGE
PHARMACY DEDUCTIBLE: Applies to all drugs except for generic oral contraceptives and other preventive drugs required by the Affordable Care Act.	$150 per individual; $300 aggregate amount per family
COVERED PRESCRIPTION DRUGS[1]:	
• **Generic Drugs**	
○ From a Participating Pharmacy	$15 Copayment per 30-day supply ($45 per 90-day supply[2])
○ Mail-order	$30 Copayment per 90-day supply[2]
• **Preferred Brand Drugs**	
○ From a Participating Pharmacy	$45 Copayment per 30-day supply ($135 per 90-day supply[2])
○ Mail-order	$113 Copayment per 90-day supply[2]
• **Non-Preferred Brand Drugs**	
○ From a Participating Pharmacy	$70 Copayment per 30-day supply ($210 per 90-day supply[2])
○ Mail-order	$175 Copayment per 90-day supply[2]
• **Biological Drugs, Biotechnical Drugs, and Specialty Pharmaceuticals[3, 4]**	80% Coverage
• **Oral Contraceptives**	$0 Copayment for generic and select brand drugs; Applicable Copayment for other brand drugs
• **Weight Loss Drugs (Contrave, Qsymia, Saxenda, and Wegovy)[5]**	70% Coverage after $200 weight loss drug deductible per member
• **Diabetic Testing Supplies**	100% Coverage

[1]Some medications may require prior authorization from VIVA HEALTH. For further information, please contact Customer Service at the phone number listed below. [2]A 90-day supply is as written by the provider, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. [3]May be administered in the home, physician's office or on an outpatient basis. There is a member out-of-pocket maximum of $2,000 per member per Calendar Year for biological, biotechnical drugs, and specialty pharmaceuticals. This out-of-pocket maximum does not apply to drugs prescribed for weight loss. When these medications are received from Express Scripts, they must be ordered by calling 1-800-803-2523. For a list of medications in this category, please refer to www.vivahealth.com/Group/Login. [4]Cost Sharing for certain specialty drugs may vary and be set to the maximum of any available manufacturer-funded copay assistance programs and is not applied to the deductible or out-of-pocket maximum. [5]Cost Sharing for weight loss drugs (Contrave, Qsymia, Saxenda, and Wegovy) does not apply to drugs prescribed for diabetes. Cost Sharing for drugs prescribed for diabetes follows standard formulary tiering.

When generic is available, Member pays difference between generic and brand price ("ancillary charge"), plus Copayment. Ancillary charges do not count toward the out-of-pocket maximum. Check with your participating pharmacy to learn if it is eligible to offer a 90-day supply at retail.

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.

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

Eligible Dependent: Eligible Employee's spouse (including common-law) and children of Eligible Employees under age 26 or disabled dependents who meet eligibility criteria.

Pre-Existing Condition Policy: No waiting period for pre-existing conditions.

Nondiscrimination Notice: VIVA HEALTH complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (including sex characteristics, including interstitial intersex traits; pregnancy or related conditions; sexual orientation; gender identity; and sex stereotypes). VIVA HEALTH does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex..

Language Assistance Services: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-294-7780 (TTY: 711).
注意：如果您使用繁體中文，您可以免費獲得語言援助服務. 請致電 1-800-294-7780 (TTY：711).

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