

## 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
<p><b>CALENDAR YEAR OUT-OF-POCKET MAXIMUM:</b> 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 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.</p>	\$7,350 per individual; \$14,700 per family
<p><b>PREVENTIVE CARE:</b></p> <ul style="list-style-type: none"> <li>• <b>Well Baby Care</b> (Children under age 3)</li> <li>• <b>Routine Physicals</b> (One per Calendar Year for 3+)</li> <li>• <b>Covered Immunizations</b></li> <li>• <b>Preventive Prenatal Care</b></li> <li>• <b>OB/GYN Preventive Visit</b> (One per Calendar Year)</li> <li>• <b>Other Preventive Items and Services</b> (See Certificate of Coverage for details)</li> </ul>	\$0 Copayment
<p><b>OTHER PRIMARY CARE SERVICES:</b></p> <ul style="list-style-type: none"> <li>• <b>Medical Physician Services</b></li> <li>• <b>Hearing Exams</b></li> <li>• <b>Illness and Injury</b></li> <li>• <b>X-Ray and Laboratory Procedures</b> <ul style="list-style-type: none"> <li>○ Covered Genetic Testing</li> </ul> </li> </ul>	\$20 Copayment/visit at UAB; \$30 Copayment/visit outside UAB \$20 Copayment/visit at UAB; \$30 Copayment/visit outside UAB \$20 Copayment/visit at UAB; \$30 Copayment/visit outside UAB 100% Coverage 80% Coverage
<p><b>SPECIALTY CARE:</b> (No PCP Referral Required)</p> <ul style="list-style-type: none"> <li>• <b>Medical Physician Services</b></li> <li>• <b>Illness and Injury</b></li> <li>• <b>X-Ray and Laboratory Procedures</b> <ul style="list-style-type: none"> <li>○ Covered Genetic Testing</li> </ul> </li> <li>• <b>OB/GYN Services</b></li> </ul>	\$20 Copayment/visit at UAB; \$30 Copayment/visit outside UAB \$20 Copayment/visit at UAB; \$30 Copayment/visit outside UAB 100% Coverage 80% Coverage \$0 Copayment/visit at UAB; \$50 Copayment/visit outside UAB
<p><b>URGENT CARE CENTER SERVICES:</b></p> <ul style="list-style-type: none"> <li>• <b>Medical Physician Services</b></li> <li>• <b>Illness and Injury</b></li> </ul>	\$20 Copayment/visit at UAB; \$30 Copayment/visit outside UAB
<p><b>EMERGENCY ROOM SERVICES:</b></p>	\$100 Copayment/visit (Copayment waived if admitted to hospital)
<p><b>EMERGENCY AMBULANCE SERVICES:</b> (Must be Medically Necessary)</p>	80% Coverage
<p><b>VISION CARE:</b> (No PCP Referral Required)</p> <ul style="list-style-type: none"> <li>• <b>Routine vision exam (one per Calendar Year) and other eye care office visits</b></li> </ul>	\$20 Copayment/visit
<p><b>ALLERGY SERVICES:</b> (No PCP Referral Required)</p> <ul style="list-style-type: none"> <li>• <b>Physician Services</b></li> <li>• <b>Testing</b></li> </ul>	\$20 Copayment/visit 80% Coverage
<p><b>DIAGNOSTIC SERVICES:</b> (Excluding inpatient and ER; including but not limited to CT Scan, MRI, PET/SPECT, ERCP)</p>	For CT Scan, MRI, and PET only <sup>1</sup> : <ul style="list-style-type: none"> <li>• \$100 Copayment/service at UAB or Children's Hospital facilities</li> <li>• \$400 Copayment/service outside UAB and Children's Hospital facilities</li> </ul> All other diagnostic services: \$150 Copayment/service
<p><sup>1</sup>\$1,200 out-of-pocket maximum per member per Calendar Year</p>	
<p><b>OUTPATIENT SERVICES:</b></p> <ul style="list-style-type: none"> <li>• <b>Surgery and Other Outpatient Services</b> (Non-OB/GYN)</li> <li>• <b>OB/GYN Outpatient Surgery and Other Procedures</b></li> <li>• <b>OB/GYN Outpatient Physician Services</b> (Surgical Procedures)</li> </ul>	\$150 Copayment/service \$0 Copayment/service at UAB; \$250 Copayment/service outside UAB \$0 Copayment/service at UAB; \$150 Copayment/service outside UAB
<p><b>INFERTILITY SERVICES:</b> (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.)</p> <ul style="list-style-type: none"> <li>• <b>Initial consultation and counseling session</b></li> <li>• <b>Semen analysis, HSG test, and endometrial biopsy</b></li> <li>• <b>Medically Necessary office visits and tests</b> (ultrasound, laboratory tests)</li> <li>• <b>Prescription drugs</b></li> <li>• <b>Medical services to treat infertility</b> [assisted reproductive technology (ART), including intrauterine insemination (IUI) and in vitro fertilization (IVF)]</li> </ul>	\$0 Copay/visit at UAB; \$50 Copay/visit outside UAB; One each/Lifetime \$0 Copayment; One per Lifetime \$0 Copayment Cost varies by drug \$0 Copayment/visit at UAB; \$150 Copayment/visit outside UAB
<p><b>HOSPITAL INPATIENT SERVICES:</b></p> <ul style="list-style-type: none"> <li>• <b>Physician and Facility Services</b></li> </ul>	\$250 Copayment/admission (Copayment waived at UAB)
<p><b>MATERNITY SERVICES:</b></p> <ul style="list-style-type: none"> <li>• <b>Physician Services</b> (Prenatal, delivery, and postnatal care)</li> <li>• <b>Hospitalization</b></li> </ul>	\$0 Copayment/delivery at UAB; \$150 Copayment/delivery outside UAB \$500 Copayment/admission (Copayment waived at UAB; \$1,500 out-of-pocket maximum per member per Calendar Year)
<p><b>Newborn care and other services covered <u>only</u> 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.</b></p>	



# Health Services Foundation

Effective Dates: January 1, 2023 – December 31, 2023

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MEDICAL BENEFITS	COVERAGE
<b>DURABLE MEDICAL EQUIPMENT &amp; PROSTHETIC DEVICES:</b>	80% Coverage
<b>SKILLED NURSING FACILITY SERVICES:</b> (Limited to 100 days per lifetime)	100% Coverage
<b>DIABETES SELF-MANAGEMENT EDUCATION:</b>	\$20 Copayment/visit at UAB; \$30 Copayment/visit outside UAB
<b>DIABETIC SUPPLIES:</b> Insulin covered under prescription drug rider. For Diabetic Supplies call VIVA HEALTH.	100% Coverage
<b>REHABILITATION SERVICES:</b> Physical, Speech, and Occupational Therapy	\$30 Copayment/visit
<b>HABILITATION SERVICES:</b> Physical, Speech, and Occupational Therapy and Applied Behavior Analysis (limited to a diagnosis of Autism, Autism Spectrum Disorder, or Pervasive Developmental Delay)	\$30 Copayment/visit
<b>HOME HEALTH CARE SERVICES:</b> (Limited to 60 visits per Calendar Year)	100% Coverage
<b>CHIROPRACTIC SERVICES:</b> (No PCP Referral Required)	\$30 Copayment/visit
<b>TEMPOROMANDIBULAR JOINT DISORDER:</b>	\$20 Copayment/visit
<b>SLEEP DISORDERS:</b>	\$20 Copayment/visit; \$150 Copayment/sleep study
<b>TRANSPLANT SERVICES:</b>	\$250 Hospital Copayment (Copayment waived at UAB)
<b>MENTAL HEALTH &amp; SUBSTANCE ABUSE SERVICES<sup>2</sup>:</b>	
• <b>Inpatient Services</b>	\$250 Copayment/admission (Copayment waived at UAB)
• <b>Outpatient Services</b>	\$20 Copayment/visit

<sup>2</sup>Treatment at a residential facility is not a covered service. Certain diagnoses are excluded from coverage. See the Certificate of Coverage for details—available for UAHSF employees to view on HR InTouch at [www.uab.edu/hrintouch](http://www.uab.edu/hrintouch).

PHARMACEUTICAL BENEFITS	COVERAGE
<b>PHARMACY DEDUCTIBLE:</b> 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
<b>COVERED PRESCRIPTION DRUGS<sup>3</sup>:</b>	
• <b>Generic Drugs</b>	
○ From a Participating Pharmacy	\$15 Copayment per 30-day supply
○ Mail-order	\$30 Copayment per 90-day supply
○ Participating Pharmacy	\$45 Copayment per 90-day supply
• <b>Preferred Brand Drugs</b>	
○ From a Participating Pharmacy	\$35 Copayment per 30-day supply
○ Mail-order	\$88 Copayment per 90-day supply
○ Participating Pharmacy	\$105 Copayment per 90-day supply
• <b>Non-Preferred Brand Drugs</b>	
○ From a Participating Pharmacy	\$60 Copayment per 30-day supply
○ Mail-order	\$150 Copayment per 90-day supply
○ Participating Pharmacy	\$180 Copayment per 90-day supply
• <b>Oral Contraceptives</b>	\$0 Copayment for generic drugs; Applicable Copayment for brand drugs
• <b>Biological Drugs, Biotechnical Drugs, and Specialty Pharmaceuticals<sup>4</sup></b>	80% Coverage
• <b>Diabetic Testing Supplies</b>	100% Coverage

<sup>3</sup>Some medications may require prior authorization from VIVA HEALTH. For further information, please contact Customer Service at the phone number listed below.

<sup>4</sup>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. 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](http://www.vivahealth.com/Group/Login).

**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.**

<b>DEPENDENT STUDENT BENEFITS:</b> (Emergencies and in-area care are covered under the appropriate sections set forth in the Certificate of Coverage)	Only 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. Preventive care is not covered out of the Service Area.
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VIVA HEALTH Customer Service: (205) 558-7474 or 1-800-294-7780 | Visit our Website at [www.vivahealth.com](http://www.vivahealth.com)

<b>Eligible Dependent:</b>	Eligible Employee’s spouse (including common-law) and children of Eligible Employees under age 26 or disabled dependents who meet eligibility criteria.
<b>Pre-Existing Condition Policy:</b>	No waiting period for pre-existing conditions.
<b>Nondiscrimination Notice:</b>	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.
<b>Language Assistance Services:</b>	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).