UAB POST DOCTORAL

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, plan guidelines, and exclusions, 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 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 ages 3+) • **Covered Immunizations** • **OB/GYN Preventive Visit** (One per Calendar Year) • **Preventive Prenatal Care** • **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)	100% Coverage
OTHER PRIMARY CARE SERVICES:	
• **Medical Physician Services**	$20 Copayment per visit
• **Illness and Injury**	$20 Copayment per visit
• **Hearing Exams**	$20 Copayment per visit
• **X-Ray and Laboratory Procedures**	100% Coverage
○ Covered Genetic Testing	80% Coverage
SPECIALTY CARE: *(PCP Referral Required)*	
• **Medical Physician Services**	$30 Copayment per visit
• **Illness and Injury**	$30 Copayment per visit
• **X-Ray and Laboratory Procedures**	100% Coverage
○ Covered Genetic Testing	80% Coverage
• **OB/GYN Services** *(No PCP Referral Required)*	$30 Copayment per visit
URGENT CARE CENTER SERVICES:	
• **Medical Physician Services** • **Illness and Injury**	$20 Copayment per visit at UAB Urgent Care; $30 Copayment per visit at all other urgent care centers
VISION CARE: *(No PCP Referral Required)* • **One routine vision exam per Calendar Year** • **Other eye care office visits**	$30 Copayment per visit
ALLERGY SERVICES: *(PCP Referral Required)*	
• **Physician Services**	$30 Copayment per visit
• **Testing**	100% Coverage
DIAGNOSTIC SERVICES: *(Including but not limited to CT Scan, MRI, PET/SPECT, ERCP)*	100% Coverage
OUTPATIENT SERVICES: • **Surgery and Other Outpatient Services**	100% Coverage
HOSPITAL INPATIENT SERVICES: • **Physician and Facility Services**	$250 Copayment per admission (waived at UAB)
INFERTILITY SERVICES: *(Subject to a $5,000 maximum family medical lifetime benefit and a separate $5,000 maximum family prescription drug lifetime benefit. Eligibility limited to subscriber and/or subscriber's spouse.)*	
• **Initial consultation and counseling session**	$30 Copayment per visit; One per Lifetime
• **Semen analysis, HSG test, and endometrial biopsy**	$0 Copayment; One per Lifetime
• **Medically Necessary office visits and tests** (ultrasound, laboratory tests)	$30 Copayment per visit
• **Prescription drugs**	Cost varies by tier
• **Medical services to treat infertility** [assisted reproductive technology (ART), including intrauterine insemination (IUI) and in vitro fertilization (IVF)]	100% Coverage
MATERNITY SERVICES:	
• **Physician Services** *(Prenatal, delivery, and postnatal care)*	$30 Copayment per delivery
• **Maternity Hospitalization**	$250 Copayment per admission (waived at UAB)
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.	
EMERGENCY ROOM SERVICES:	$50 Copay/visit (waived if admitted within 24 hours)
EMERGENCY AMBULANCE SERVICES: *(Must be Medically Necessary)*	100% Coverage
DURABLE MEDICAL EQUIPMENT AND PROSTHETIC DEVICES:	100% Coverage
MEDICAL NUTRITION SERVICES: *(Limited to 6 visits per Calendar Year with a Registered Dietitian or Nutritionist)*	$30 Copayment per visit

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MEDICAL BENEFITS	COVERAGE
DIABETES SELF MANAGEMENT EDUCATION:	$30 Copayment per visit
DIABETIC SUPPLIES: Insulin covered under prescription drug rider. For Diabetic Supplies call VIVA HEALTH.	100% Coverage
SKILLED NURSING FACILITY SERVICES: *(100 days per Lifetime)*	100% Coverage
HOME HEALTH CARE SERVICES: *(Limited to 60 visits per Calendar Year)*	100% Coverage
REHABILITIATION AND HABILITATION SERVICES: Physical, Speech, and Occupational Therapy and Applied Behavior Analysis	$30 Copayment per visit; $250 Copayment per admission (waived at UAB)
CHIROPRACTIC SERVICES: *(PCP Referral Required)*	$30 Copayment per visit
TEMPOROMANDIBULAR JOINT DISORDER:	$30 Copayment per visit
SLEEP DISORDERS:	$30 Copayment per visit;
• **Sleep Study**	100% Coverage
TRANSPLANT SERVICES:	100% Coverage after $250 Hospital Copayment (waived at UAB)
MENTAL HEALTH & SUBSTANCE USE DISORDER SERVICES:	
• **Inpatient Services**	100% Coverage after $250 Copay/admission (waived at UAB)
• **Outpatient Services**[1]	$30 Copayment per visit

[1]Outpatient office visits require a PCP referral.

MEDICAL BENEFITS	COVERAGE
COVERED PRESCRIPTION DRUGS[2]**:**	
• **Generic Drugs**	
○ From a Participating Pharmacy	$15 Copayment per 30-day supply
○ Mail-order	$30 Copayment per 90-day supply[3]
○ Participating Pharmacy	$45 Copayment per 90-day supply[3]
• **Preferred Brand Drugs**	
○ From a Participating Pharmacy	$45 Copayment per 30-day supply
○ Mail-order	$113 Copayment per 90-day supply[3]
○ Participating Pharmacy	$135 Copayment per 90-day supply[3]
• **Non-Preferred Brand Drugs**	
○ From a Participating Pharmacy	$70 Copayment per 30-day supply
○ Mail-order	$175 Copayment per 90-day supply[3]
○ Participating Pharmacy	$210 Copayment per 90-day supply[3]
• **Biological Drugs, Biotechnical Drugs, and Specialty Pharmaceuticals**[4,5]	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)**[6]	70% Coverage after $200 weight loss drug deductible per member
• **Diabetic Testing Supplies**	100% 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]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. [4]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 drugs, 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 https://www.vivahealth.com/Group/Login/ [5]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 out-of-pocket maximum. [6]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, 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

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

Eligible Dependent: Eligible Employee's lawful spouse and children of Eligible Employees under age 26 or disabled dependents who meet eligibility criteria. Dependents with a last name different from employee's must be verified as eligible through submission of a marriage or birth certificate with the enrollment application.

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

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).

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