




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 [www.vivahealth.com/Group/Login](http://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](http://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 <a href="#">deductible</a> ?	\$0	See the Common Medical Events chart below for your costs for services this <a href="#">plan</a> covers.
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes.	You don't have to meet <a href="#">deductibles</a> for specific services, but see the Common Medical Events chart below for other costs for services this <a href="#">plan</a> covers.
Are there other <a href="#">deductibles</a> for specific services?	Yes. \$150/individual or \$300/family for prescription drug coverage. \$200/individual for weight loss drugs. There are no other specific <a href="#">deductibles</a> .	You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	For medical/mental health: \$7,350/individual or \$14,700/family. For <a href="#">specialty drugs</a> : \$2,000 per individual per calendar year. For maternity hospitalization: \$1,500 per calendar year.	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance-billed</a> charges, health care this <a href="#">plan</a> doesn't cover, and out-of-network expenses for non-emergency and non-urgent services. Certain <a href="#">specialty drugs</a> are considered non-essential health benefits and are not applied to the <a href="#">out-of-pocket limit</a> . The cost of these drugs (reimbursed by the manufacturer at no cost to you) will not be applied toward satisfying your <a href="#">out-of-pocket limit</a> .	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.myvivaprovider.com">www.myvivaprovider.com</a> or call 1-800-294-7780 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 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)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	\$30 <a href="#">copay</a> /visit at UAB; \$40 <a href="#">copay</a> /visit outside UAB	Not covered	-----none-----
	<a href="#">Specialist</a> visit	\$30 <a href="#">copay</a> /visit at UAB; \$40 <a href="#">copay</a> /visit outside UAB	Not covered	OB/GYN: No charge for visit at UAB and \$60 <a href="#">copay</a> per visit outside UAB. Chiropractor: \$30 <a href="#">copay</a> per visit. Medical Nutritionist counseling limited to 6 visits per Calendar Year with a Nutritionist or Registered Dietitian.
	<a href="#">Preventive care/screening/immunization</a>	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 <a href="#">plan</a> will pay for.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	No charge	Not covered	Office visit or facility <a href="#">copay</a> may apply. Covered genetic testing subject to 20% <a href="#">coinsurance</a> . Genetic testing requires <a href="#">prior authorization</a> . If <a href="#">prior authorization</a> is not obtained, no charges for those services will be covered by the <a href="#">plan</a> .
	Imaging (CT/PET scans, MRIs)	CT, PET, MRI: \$100 <a href="#">copay</a> /test at UAB, Medical West, or Children's Hospital; \$400 <a href="#">copay</a> /test at other providers. For other tests, \$150 <a href="#">copay</a> /test	Not covered	Certain imaging tests require <a href="#">prior authorization</a> for <a href="#">plan</a> to pay for them. Out-of-pocket limit for CT, PET and MRI is \$1,200 per calendar year. See <a href="#">plan</a> documents for more information. If <a href="#">prior authorization</a> is not obtained, no charges for those services will be covered by the <a href="#">plan</a> .
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.vivahealth.com">www.vivahealth.com</a>	Generic drugs	\$15 <a href="#">copay</a> /prescription (retail); \$30 <a href="#">copay</a> /prescription (mail order)	Not covered	Covers up to a 30-day supply (retail); 90-day supply (mail order). No charge for generic and select brand oral contraceptive drugs. <a href="#">Deductible</a> applies to all drugs except for generic oral contraceptives and other preventive drugs required by the Affordable Care Act. <a href="#">Deductible</a> must be satisfied before <a href="#">copays</a> apply. Weight loss drugs subject to 30% <a href="#">coinsurance</a> and \$200 per member <a href="#">deductible</a> except when prescribed for diabetes.
	Preferred brand drugs	\$45 <a href="#">copay</a> /prescription (retail); \$113 <a href="#">copay</a> /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 <a href="#">copay</a> . <a href="#">Deductible</a> must be satisfied before <a href="#">copays</a> apply. Weight loss drugs subject to 30% <a href="#">coinsurance</a> and \$200 per member <a href="#">deductible</a> except when prescribed for diabetes.

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.vivahealth.com/Group/Login](http://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 <a href="#">copay</a> /prescription (retail); \$175 <a href="#">copay</a> /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 <a href="#">copay</a> . <a href="#">Deductible</a> must be satisfied before <a href="#">copays</a> apply. Weight loss drugs subject to 30% <a href="#">coinsurance</a> and \$200 per member <a href="#">deductible</a> except when prescribed for diabetes.
	Specialty drugs	20% <a href="#">coinsurance</a>	Not covered	Requires <a href="#">prior authorization</a> for <a href="#">plan</a> to pay for drugs. Call 1-800-803-2523. If <a href="#">prior authorization</a> is not obtained, no charges for those services will be covered by the <a href="#">plan</a> . <a href="#">Deductible</a> must be satisfied before <a href="#">coinsurance</a> applies. <a href="#">Out-of-pocket limit</a> for <a href="#">specialty drugs</a> is \$2,000 per individual per calendar year. <a href="#">Coinsurance</a> for certain <a href="#">specialty drugs</a> may vary and be set to the maximum of any available manufacturer-funded <a href="#">copay</a> assistance programs. Benefits for some specialty drugs will be coordinated through the SaveOn program. Please see "Important Questions" regarding the plan's <a href="#">out-of-pocket limit</a> .
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$150 <a href="#">copay</a> /service	Not covered	Requires <a href="#">prior authorization</a> for <a href="#">plan</a> to pay. For OB/GYN outpatient surgery, no facility or physician charge at UAB and \$250 facility <a href="#">copay</a> and \$150 physician <a href="#">copay</a> outside UAB. If <a href="#">prior authorization</a> is not obtained, no charges for those services will be covered by the <a href="#">plan</a> .
	Physician/surgeon fees	No charge	Not covered	Requires <a href="#">prior authorization</a> for <a href="#">plan</a> to pay. For OB/GYN outpatient surgery, no facility or physician charge at UAB and \$250 facility <a href="#">copay</a> and \$150 physician <a href="#">copay</a> outside UAB. If <a href="#">prior authorization</a> is not obtained, no charges for those services will be covered by the <a href="#">plan</a> .
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$100 <a href="#">copay</a> /visit	\$100 <a href="#">copay</a> /visit	Limited to <a href="#">emergency medical conditions</a> . Follow-up care is not covered. See <a href="#">plan</a> documents for more information.
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Limited to transportation to a hospital.
	<a href="#">Urgent care</a>	\$30 <a href="#">copay</a> /visit at UAB; \$40 <a href="#">copay</a> /visit outside UAB ( <a href="#">urgent care center</a> )	\$40 <a href="#">copay</a> /visit ( <a href="#">urgent care center</a> )	Coverage from non-participating providers is limited to care outside the VIVA HEALTH service area and requires <a href="#">prior authorization</a> or a <a href="#">referral</a> from a participating provider. If <a href="#">prior authorization</a> or a <a href="#">referral</a> is not obtained, no charges for those services will be covered by the <a href="#">plan</a> .
If you have a hospital stay	Facility fee (e.g., hospital room)	\$250 <a href="#">copay</a> /admission; No charge at UAB	Not covered except for <a href="#">emergency medical conditions</a>	Requires <a href="#">prior authorization</a> for <a href="#">plan</a> to pay for admission except for <a href="#">emergency medical conditions</a> . If <a href="#">prior authorization</a> is not obtained, no charges for those services will be covered by the <a href="#">plan</a> .

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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 <a href="#">emergency medical conditions</a>	Requires <a href="#">prior authorization</a> for <a href="#">plan</a> to pay for admission except for <a href="#">emergency medical conditions</a> . If <a href="#">prior authorization</a> is not obtained, no charges for those services will be covered by the <a href="#">plan</a> .
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$30 <a href="#">copay</a> /visit	Not covered	Partial Hospitalization and Intensive Outpatient Program services require <a href="#">prior authorization</a> for <a href="#">plan</a> to pay for admission. If <a href="#">prior authorization</a> is not obtained, no charges for those services will be covered by the <a href="#">plan</a> .
	Inpatient services	\$250 <a href="#">copay</a> /admission; No charge at UAB	Not covered except for <a href="#">emergency medical conditions</a>	Requires <a href="#">prior authorization</a> for <a href="#">plan</a> to pay for admission. If <a href="#">prior authorization</a> is not obtained, no charges for those services will be covered by the <a href="#">plan</a> .
<b>If you are pregnant</b>	Office visits	\$150 <a href="#">copay</a> /delivery; No charge at UAB	Not covered	No coverage for surrogate pregnancy. <a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Maternity care may include tests and services described elsewhere in the SBC. See <a href="#">plan</a> documents for more information. <a href="#">Out-of-pocket limit</a> for maternity hospitalization is \$1,500 per calendar year.
	Childbirth/delivery professional services	No charge	Not covered	
	Childbirth/delivery facility services	\$500 <a href="#">copay</a> /admission; No charge at UAB	Not covered	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	No charge	Not covered	Requires <a href="#">prior authorization</a> for <a href="#">plan</a> to pay for care. Limited to 60 visits per calendar year. If <a href="#">prior authorization</a> is not obtained, no charges for those services will be covered by the <a href="#">plan</a> .
	<a href="#">Rehabilitation services</a>	\$30 <a href="#">copay</a> /visit	Not covered	Requires <a href="#">prior authorization</a> for <a href="#">plan</a> to pay for therapy. If <a href="#">prior authorization</a> is not obtained, no charges for those services will be covered by the <a href="#">plan</a> .
	<a href="#">Habilitation services</a>	\$30 <a href="#">copay</a> /visit	Not covered	Requires <a href="#">prior authorization</a> for <a href="#">plan</a> to pay for therapy. If <a href="#">prior authorization</a> is not obtained, no charges for those services will be covered by the <a href="#">plan</a> .
	<a href="#">Skilled nursing care</a>	No charge	Not covered	Requires <a href="#">prior authorization</a> for <a href="#">plan</a> to pay for care. Limited to 100 days per lifetime. If <a href="#">prior authorization</a> is not obtained, no charges for those services will be covered by the <a href="#">plan</a> .
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	Not covered	Requires <a href="#">prior authorization</a> for <a href="#">plan</a> to pay for service. If <a href="#">prior authorization</a> is not obtained, no charges for those services will be covered by the <a href="#">plan</a> .
	<a href="#">Hospice services</a>	No charge	Not covered	Requires <a href="#">prior authorization</a> for <a href="#">plan</a> to pay for service. Limited to 180 days per lifetime. If <a href="#">prior authorization</a> is not obtained, no charges for those services will be covered by the <a href="#">plan</a> .

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.vivahealth.com/Group/Login](http://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)	
<b>If your child needs dental or eye care</b>	Children's eye exam	\$30 <a href="#">copay</a> /visit	Not covered	Limited to one routine visit per calendar year and medically necessary visits for illness or injury.
	Children's glasses	Not covered	Not covered	<a href="#">Excluded service.</a>
	Children's dental check-up	Not covered	Not covered	<a href="#">Excluded service.</a>

### 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
- Infertility treatment
- Routine eye care
- 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 Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://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](http://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 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).

### Does this plan provide Minimum Essential Coverage? **Yes**

[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.*



## 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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist copayment</a>	\$30
■ Hospital (facility) <a href="#">copayment</a>	\$0
■ Other <a href="#">cost-sharing</a>	\$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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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#### In this example, Peg would pay:

Cost Sharing	
Deductibles	\$10
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$70</b>

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist copayment</a>	\$30
■ Hospital (facility) <a href="#">copayment</a>	\$250
■ Other <a href="#">coinsurance</a>	20%

#### 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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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#### In this example, Joe would pay:

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

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist copayment</a>	\$30
■ Hospital (facility) <a href="#">copayment</a>	\$250
■ Other <a href="#">cost-sharing</a>	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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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#### In this example, Mia would pay:

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

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