VIVA UAB

Effective Dates: January 1, 2026 – December 31, 2026

Attachment A to Certificate of Coverage

The Plan's services and benefits, with their copayments, coinsurance, and some of the limitations, are listed below. This is only a brief listing. For further information, plan guidelines, and exclusions, please see the Certificate of Coverage. As a member of VIVA UAB, you have access to the UAB Health System, including UAB St. Vincent's, Cooper Green, and Medical West for primary care, OB/GYN, and other health care services. You have access to our entire network of podiatry, optometry, ophthalmology, pain management, allergy and immunology, mental health, substance use disorder, and chiropractic providers. VIVA UAB members under the age of 18 have access to VIVA HEALTH's entire pediatric network with no referral required. **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 deductibles, 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.	$5,000 per individual; $10,000 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/Calendar Year w/ 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** • **Illness and Injury** • **Hearing Exams** • **X-Ray and Laboratory Procedures** ○ Covered Genetic Testing	 $30 Copayment per visit 80% Coverage
SPECIALTY CARE: *(PCP Referral Required)* • **Medical Physician Services** • **Illness and Injury** • **OB/GYN Services** (No PCP Referral Required) • **X-Ray and Laboratory Procedures** ○ Covered Genetic Testing	 $45 Copayment per visit 80% Coverage
URGENT CARE CENTER SERVICES: • **Medical Physician Services** • **Illness and Injury**	 $30 Copay/visit at UAB Urgent Care; $45 Copay/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**	 $45 Copayment per visit
ALLERGY SERVICES: *(No PCP Referral Required)* • **Physician Services** • **Testing**	 $45 Copayment per visit 80% Coverage
DIAGNOSTIC SERVICES: *(Including but not limited to CT Scan, MRI, PET/SPECT, ERCP)*	$150 Copayment per service
OUTPATIENT SERVICES: • **Surgery and Other Outpatient Services**	$200 Copayment per visit
HOSPITAL INPATIENT SERVICES: • **Physician and Facility Services**	$300 Copayment per admission
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** • **Semen analysis, HSG test, and endometrial biopsy** • **Medically Necessary office visits and tests** (ultrasound, laboratory tests) • **Prescription drugs** • **Medical services to treat infertility** [assisted reproductive technology (ART), including intrauterine insemination (IUI) and in vitro fertilization (IVF)]	 $45 Copayment per visit; One per Lifetime $0 Copayment; One per Lifetime $45 Copayment per visit Cost varies by tier $150 Copayment per visit
MATERNITY SERVICES: • **Physician Services** (Prenatal, delivery, and postnatal care) • **Maternity Hospitalization**	 $45 Copayment per delivery $300 Copayment per admission
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.	
EMERGENCY ROOM SERVICES: Members can use participating urgent care facilities in urgent but non-emergency situations	$125 Copayment per visit (waived if admitted within 24 hours)

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MEDICAL BENEFITS	COVERAGE
EMERGENCY AMBULANCE SERVICES: *(Must be Medically Necessary)*	80% Coverage
DURABLE MEDICAL EQUIPMENT AND PROSTHETIC DEVICES:	80% Coverage
SKILLED NURSING FACILITY SERVICES: *(Limited to 60 days per Calendar Year)*	80% Coverage
HOME HEALTH CARE SERVICES: *(Limited to 60 visits per Calendar Year)*	80% Coverage
CHIROPRACTIC SERVICES: *(PCP Referral Required)*	$45 Copayment per visit
MEDICAL NUTRITION SERVICES: *(Limited to 6 visits per Calendar Year with a Registered Dietitian or Nutritionist)*	$45 Copayment per visit
DIABETES SELF-MANAGEMENT EDUCATION:	$45 Copayment per visit
DIABETIC SUPPLIES: Insulin covered under prescription drug rider. For Diabetic Supplies call VIVA HEALTH.	100% Coverage
REHABILITIATION AND HABILITATION SERVICES: Physical, Speech, and Occupational Therapy and Applied Behavior Analysis	$45 Copayment per visit; $300 Copayment per admission
SLEEP DISORDERS: • **Sleep Study**	$45 Copayment per visit; $150 Copayment per sleep study
TEMPOROMANDIBULAR JOINT DISORDER:	$45 Copayment per visit
TRANSPLANT SERVICES:	100% Coverage after $300 Hospital Copay
MENTAL HEALTH & SUBSTANCE USE DISORDER SERVICES:	
• **Inpatient Services**	$300 Copayment per admission
• **Outpatient Services**	$45 Copayment per 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	$20 Copay per 30-day supply ($60 per 90-day supply[2])
○ Mail-order	$40 Copay per 90-day supply[2]
• **Preferred Brand Drugs**	
○ From a Participating Pharmacy	$50 Copay per 30-day supply ($150 per 90-day supply[2])
○ Mail-order	$125 Copay per 90-day supply[2]
• **Non-Preferred Brand Drugs**	
○ From a Participating Pharmacy	$75 Copay per 30-day supply ($225 per 90-day supply[2])
○ Mail-order	$185 Copay per 90-day supply[2]
• **Specialty Drugs[3,4]**	80% Coverage
• **Oral Contraceptives**	$0 Copay for generic and select brand drugs; Applicable Copay for other brand drugs
• **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. 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/. [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.

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

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 Copays described herein and a $1,500 max benefit per Calendar Year.

SABBATICAL: (Sabbatical leave is a period of paid leave granted to faculty members by the Employer to pursue professional development, a program of investigation, creative writing, or artistry, and the like.) Services to treat an illness or injury for Subscribers and Covered Dependents on Sabbatical Leave will be covered while they are 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/uab

Eligible Dependent: To be eligible to enroll as a Covered Dependent, a person must be listed on the enrollment application completed by the Subscriber, reside in the Service Area or with the Subscriber (exceptions apply), and meet additional qualifying criteria. For exceptions and additional qualifying criteria, please refer to the Certificate of Coverage.

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