THE UNIVERSITY OF ALABAMA AT BIRMINGHAM STUDENT HEALTH PLAN

Effective Dates: August 15, 2016 – August 14, 2017

Attachment A to Certificate of Coverage – Summary of Benefits

The Plan's services and benefits, with its coinsurance and some of the limitations, are listed below. Please remember that this is only a brief listing. For further information and plan exclusions, please see the Certificate of Coverage. Except in emergencies, Students in Birmingham must seek care from UAB Student Health Services (SHS). Care from other participating providers will not be covered without a referral from SHS. Students will not be referred outside SHS, if services are available from SHS. Students in Tuscaloosa and Huntsville may use the VIVA HEALTH network. Spouses and dependents age 18 and over must seek care from a UAB provider listed in the UAB Student Provider Directory. Children (age 17 and under) may use any VIVA HEALTH participating provider. VIVA HEALTH's OB/GYN providers may be used for OB/GYN services only. No referral necessary for Students to see participating UAB orthopedists.

Please keep this Attachment A for your records.

BENEFITS	COVERAGE
PLAN YEAR DEDUCTIBLE: The family deductible is $500, not to exceed $250 per any individual. Applies ONLY to those benefits with coinsurance when the Member pays a set percentage of the cost. Does not apply to services from UAB Student Health Services or Biological, Biotechnical, and Specialty Pharmaceuticals ordered through Express Scripts but will apply to such drugs when provided directly by a physician or hospital.	$250 per individual; $500 per family
PLAN YEAR OUT-OF-POCKET MAXIMUM: The most a member will pay per year for qualified medical, mental, and substance abuse 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. The family out-of-pocket maximum is $8,000 not to exceed$4,000 per any individual.	$4,000 per individual; $8,000 per family
PREVENTIVE CARE:	
• **Well Baby Care** *(Children under age 3)*	$0 Copayment per visit
• **Routine Physicals** *(One per Calendar Year for ages 3+)*	
• **Covered Immunizations**	
• **OB/GYN Preventive Visit** *(One per Calendar Year)*	
• **Other preventive items and services. See Certificate of Coverage for more information**	
OTHER PRIMARY CARE SERVICES:	
• **Office Visits**	$0 Copayment for Students at UAB Student Health Services
o Illness and Injury	$20 Copayment per visit for Covered Dependents
o Hearing Exams	
• **Other Services** *(Including but not limited to lab, anesthesia, supplies, facility charges)*	90% Coverage; subject to deductible
*Any student visit outside of UAB Student Health Services must be authorized by VIVA HEALTH and will be covered at a $20 Copayment	
SPECIALTY CARE: *(PCP referral required)*	
• **Physician Services**	$0 Copayment for Students at UAB Student Health Services; $25 Copayment per visit for Covered Dependents
• **OB/GYN Services** *(No PCP referral required)*	$25 Copayment within the VIVA HEALTH network
• **Other Services** *(lab, anesthesia, supplies, facility charges)*	90% Coverage; subject to deductible
URGENT CARE CENTER SERVICES:	
• **Medical Physician Services**	$25 Copayment per visit
• **Illness and Injury**	
VISION CARE:	
• **One routine vision exam every plan year** *(For members 19+; No PCP referral required)*	$25 Copayment per visit
• **Other eye care office visits** *(No PCP referral required)*	$25 Copayment per visit
PEDIATRIC VISION CARE: (Covered for children ages 0 until age 19; No PCP Referral Required)	
• **One routine vision exam every 12 months for children ages 0 until age 19**	100% Coverage
• **Contacts or one pair of eyeglasses every 12 months for children ages 0 until age 19**	100% Coverage
*These benefits are administered by VSP. Children must use VSP Advantage providers for routine eye exam and eyewear. Covered eyewear selected by VSP. Find VSP providers at www.vsp.com/advantage or call 855-868-4561.	
PEDIATRIC DENTAL CARE: (Covered for children ages 0 until age 19)	Pediatric dental benefits provided by Delta Dental PPO. For more information, go to www.deltadentalins.com/vivaehb or call 1-800-471-8148
ALLERGY SERVICES: *(PCP referral required)*	
• **Physician Office Visits**	$25 Copayment per visit
• **Testing, Injections, and other Treatment**	90% Coverage; subject to deductible
CHRONIC CARE MAINTENANCE: *(Including but not limited to dialysis, radiation therapy, wound care, wound therapy)*	90% Coverage; subject to deductible
LABORATORY SERVICES:	
• **Laboratory Procedures**	90% Coverage; subject to deductible
• **Covered Genetic Testing**	80% Coverage; subject to deductible
DIAGNOSTIC SERVICES:	
• **X-Rays**	$10 Copayment per image
• **Other Diagnostic Services** *(Including but not limited to CT Scan, MRI, EKG, PET/SPECT, ERCP)*	90% Coverage; subject to deductible
OUTPATIENT SERVICES:	
• **Surgery and Other Outpatient Services**	90% Coverage; subject to deductible
HOSPITAL INPATIENT SERVICES:	
• **Physician Services**	90% Coverage; subject to deductible
• **Semi-private room**	90% Coverage; subject to deductible

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BENEFITS	COVERAGE
MATERNITY SERVICES:	
• **Physician Services**	$25 Copayment per delivery
• **Maternity Hospitalization**	90% Coverage; subject to deductible
*Newborn care and other services covered only for enrolled child of student or student's spouse. Eligible child must be enrolled within 30 days of birth or adoption. No coverage for children of student's dependent child.	
EMERGENCY ROOM SERVICES:	$100 Copayment per visit (waived if admitted through Emergency Room)
EMERGENCY AMBULANCE SERVICES:	90% Coverage; subject to deductible
DURABLE MEDICAL EQUIPMENT & PROSTHETIC DEVICES:	90% Coverage; subject to deductible
DIABETIC SUPPLIES: Insulin covered under prescription drug rider. For Diabetic Supplies call VIVA HEALTH.	90% Coverage; subject to deductible
REHABILITATION SERVICES: Physical, Speech, and Occupational Therapy *(Limited to 60 total inpatient days and 25 total outpatient visits per Plan Year)*	90% Coverage; subject to deductible
HOME HEALTH CARE SERVICES:	90% Coverage; subject to deductible
CHIROPRACTIC SERVICES: *(PCP Referral Required)* (Covered up to 25 visits per Plan Year)	90% Coverage; subject to deductible
TEMPOROMANDIBULAR JOINT DISORDER: ($2,000 maximum benefit per Lifetime)	90% Coverage; subject to deductible
MENTAL HEALTH & SUBSTANCE ABUSE SERVICES:	
• **Mental Health**	
o Inpatient	90% Coverage; subject to deductible
o Outpatient	$25 Copayment per visit
• **Psychiatrist Office Visit**	$25 Copayment per visit
• **Substance Abuse**	
o Inpatient	90% Coverage; subject to deductible
o Outpatient	$25 Copayment per visit
Treatment at a residential facility is not a covered service. Certain diagnoses are excluded from coverage. See your Certificate of Coverage for details.	
COVERED PRESCRIPTION DRUGS:	
• **Generic Drugs (Tier 1 & 2)**	
o Participating Pharmacy	$12 Copayment per 31-day supply
o Mail-order	$30 Copayment per 90-day supply
o Participating Pharmacy	$36 Copayment per 90-day supply
• **Preferred Brand-Name Drugs (Tier 3)**	
o Participating Pharmacy	$30 Copayment per 31-day supply
o Mail-order	$75 Copayment per 90-day supply
o Participating Pharmacy	$90 Copayment per 90-day supply
• **Non-Preferred Brand-Name Drugs (Tier 4)**	
o Participating Pharmacy	$50 Copayment per 31-day supply
o Mail-order	$125 Copayment per 90-day supply
o Participating Pharmacy	$150 Copayment per 90-day supply
• **Oral Contraceptives**	$0 Copayment for select generic drugs; Applicable Copayment for other generic drugs and all brand-name drugs
* *When generic is available, Member pays difference between generic and brand name price, plus Copayment. Check with your Participating Pharmacy to learn if it is eligible to offer a 90-day supply at retail.*	
BIOLOGICAL DRUGS, BIOTECHNICAL DRUGS, AND SPECIALTY PHARMACEUTICALS (TIER 5 & 6):	80% Coverage
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 full list of medications in this category, please refer to www.vivahealth.com.	
TRANSPLANT SERVICES:	90% Coverage; subject to deductible
SLEEP DISORDERS *(Two sleep Studies per Lifetime)*	90% Coverage; subject to deductible
SKILLED NURSING FACILITY SERVICES:	Not Covered

PRE-EXISTING CONDITION POLICY: No pre-existing condition exclusions or waiting period.

ACTUARIAL VALUE: This plan is considered a platinum plan, with an actuarial value of 88.9%.

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.

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）。

VIVA HEALTH Customer Service: (205) 558-7474 or 1-800-294-7780

Visit our Website at www.vivahealth.com