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VIVA HEALTH

Attachment A to Certificate of Coverage

The Plan's services and benefits, with its copayments and some of the limitations, are listed below. 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.**

BENEFITS	COVERAGE
CALENDAR YEAR DEDUCTIBLE: *The family deductible is $750, not to exceed $250 per any individual. Applies ONLY to those benefits with 90% Coverage.*	$250 per individual; $750 aggregate amount per family
PRIMARY CARE SERVICES:	
• **Preventive Care & Other Office Visits** ♦ *Routine Physicals (one per Calendar Year)* ♦ *Covered Immunizations* ♦ *Hearing Exams* ♦ *X-Rays and Laboratory Procedures* ♦ *Illness and Injury*	100% after $20 physician copay with no deductible
SPECIALTY CARE: *(No PCP Referral Required)*	
• **Surgical & Medical Physician Services**	100% after $20 physician copay with no deductible
• **X-Ray and Laboratory Procedures**	100% coverage
• **OB/GYN Services** (One OB/GYN preventive visit every Calendar Year)	100% after $20 physician copay with no deductible
VISION CARE: *(No PCP Referral Required)*	
• **One routine vision exam every 12 months**	100% after $20 physician copay with no deductible
• **Other eye care office visits**	100% after $20 physician copay with no deductible
ALLERGY SERVICES: *(No PCP Referral Required)*	
• **Physician Services**	100% after $20 physician copay with no deductible
• **Testing**	90% Coverage; subject to deductible and out-of-pocket max
DIAGNOSTIC SERVICES: *(Including but not limited to CT Scan, MRI, PET/SPECT, ERCP)*	90% Coverage; subject to deductible and out-of-pocket max
OUTPATIENT SERVICES:	
• **Surgery & Other Outpatient Services**	90% Coverage; subject to deductible and out-of-pocket max
HOSPITAL INPATIENT SERVICES:	
• **Physician Services**	90% Coverage; subject to deductible and out-of-pocket max
• **Semi-private Room**	90% Coverage; subject to deductible and out-of-pocket max
MATERNITY SERVICES:	
• **Physician Services** *Prenatal, delivery and postnatal care*	$20 Copayment (*per delivery*)
• **Maternity Hospitalization**	90% Coverage; subject to deductible and out-of-pocket max
EMERGENCY ROOM SERVICES:	100% after $100 copay with no deductible *(Copay waived if admitted through ER)*
EMERGENCY AMBULANCE SERVICES:	90% Coverage; subject to deductible and out-of-pocket max
DURABLE MEDICAL EQUIPMENT & PROSTHETIC DEVICES: (Maximum Benefit of $15,000 per Lifetime)	90% Coverage; subject to deductible and out-of-pocket max
SKILLED NURSING FACILITY SERVICES: (100 Days per Lifetime)	90% Coverage; subject to deductible and out-of-pocket max
DIABETIC SUPPLIES: Insulin covered under prescription drug rider. For Diabetic Supplies call VIVA Health.	90% Coverage; subject to deductible and out-of-pocket max
REHABILITATION SERVICES: Physical, Speech, and Occupational Therapy (Limited to 60 Total Inpatient Days and 20 Total Outpatient Visits per Calendar Year)	90% Coverage; subject to deductible and out-of-pocket max
HOME HEALTH CARE SERVICES: (Limited to 60 Visits per Calendar Year)	90% Coverage; subject to deductible and out-of-pocket max

CHIROPRACTIC SERVICES: *(No PCP Referral Required)* (Covered up to 20 Visits per Calendar Year) • **Treatment for manual manipulation of subluxations only**	100% after $20 copay with no deductible
TEMPOROMANDIBULAR JOINT DISORDER: **(**$2,000 Maximum Benefit per Lifetime)	90% Coverage; subject to deductible and out-of-pocket max
SLEEP DISORDERS: $3,000 Maximum Benefit per Lifetime	90% Coverage; subject to deductible and out-of-pocket max *(one sleep study per lifetime)*
TRANSPLANT SERVICES:	90% Coverage; subject to deductible and out-of-pocket max
MENTAL HEALTH & SUBSTANCE ABUSE SERVICES: • Mental Health: ♦ Inpatient (Subject to a 30 Day Combined Maximum for MH/SA per Calendar Year) ♦ Outpatient (Subject to a 20 Visit Combined Maximum for MH/SA per Calendar Year) • Substance Abuse: *(Detox Only)* ♦ Inpatient (Detox Limited to 3 Days per Calendar Year) ($5,000 Maximum Coinsurance per Member per Calendar Year for Mental Health and Substance Abuse Services.)	50% Coverage 100% Coverage after $50 copayment per visit 50% Coverage
COVERED PRESCRIPTION DRUGS: (Coverage limited to $3,000 per member per Calendar Year. Member copayments and coinsurance do not count toward this coverage limit.) • **Generic Drugs** ♦ From a Participating Pharmacy ♦ Mail-order • **Preferred Brand-Name Drugs** ♦ From a Participating Pharmacy ♦ Mail-order • **Non-Preferred Brand-Name Drugs** ♦ From a Participating Pharmacy ♦ Mail-order	 $15 Copayment per 31-day supply $38 Copayment per 90-day supply $30 Copayment per 31-day supply $75 Copayment per 90-day supply $60 Copayment per 31-day supply $150 Copayment per 90-day supply
• **Biological Drugs, Biotechnical Drugs, and Specialty Pharmaceuticals** (The prescription coverage limit does not apply. There is a member out of pocket maximum of $10,000 per member per Calendar Year for biological drugs, biotechnical drugs and specialty pharmaceuticals. Administered in the home, physician's office or on an outpatient basis. These drugs must be obtained from VIVA Health's specialized pharmacy provider. For a listing of these drugs, see our website at www.vivahealth.com.)	90% Coverage
• **Mental Nervous Drugs**	50% Coverage
Some medications may require prior authorization from VIVA HEALTH. For further information, please contact Customer Service at the phone number listed below.	***When Generic is available, Member pays difference between Generic and Brand-Name price, plus Copayment***
CALENDAR YEAR OUT-OF-POCKET MAXIMUM: *Applies ONLY to those benefits with 90% Coverage that are subject to the Deductible.*	$2,000 per individual; $4,000 aggregate amount per family
Lifetime maximum benefit per member:	**$1,000,000**

VIVA HEALTH CUSTOMER SERVICE (205) 558-7474 or (800) 294-7780
VISIT OUR WEBSITE at www.vivahealth.com

Pre-Existing Condition Policy: Coverage will be excluded for twelve (12) months following the effective date of coverage due to a pre-existing condition. A pre-existing condition is a condition for which medical advice, diagnosis, care or treatment was recommended or received during the six (6) months immediately preceding the effective date of coverage. Pregnancy is not considered a pre-existing condition and no pre-existing condition shall apply to a dependent newborn or adopted child if covered within 30 days of birth or adoption. VIVA Health will waive the pre-existing condition waiting period for the period of time an individual was previously covered by qualifying previous coverage provided that qualifying previous coverage was continuous to a date not more than sixty-three (63) days prior to the effective date of coverage. This period of time does not include a new hire waiting period.