

Attachment A to Certificate of Coverage

The Plan's services and benefits, with their 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
PRIMARY CARE SERVICES: <ul style="list-style-type: none"> • Preventive Care & Other Office Visits <ul style="list-style-type: none"> • Routine Physicals • Covered Immunizations • Hearing Exams • Illness and Injury • X-Rays and Laboratory Procedures 	\$20 Copayment per visit
SPECIALTY CARE: (No PCP Referral Required) <ul style="list-style-type: none"> • Surgical & Medical Physician Services • X-Ray and Laboratory Procedures • OB/GYN Services (One OB/GYN preventive visit per Calendar Year) 	\$30 Copayment per visit 100% Coverage \$30 Copayment per visit
VISION CARE: (No PCP referral required) <ul style="list-style-type: none"> • One routine vision exam every 12 months • Other eye care office visits 	\$30 Copayment per visit \$30 Copayment per visit
ALLERGY SERVICES: (No PCP Referral Required) <ul style="list-style-type: none"> • Physician Services • Testing 	\$30 Copayment per visit 100% Coverage
DIAGNOSTIC SERVICES: (Including but not limited to CT Scan, MRI, PET/SPECT, ERCP)	100% Coverage
OUTPATIENT SERVICES: <ul style="list-style-type: none"> • Surgery and Other Outpatient Services 	100% Coverage
HOSPITAL INPATIENT SERVICES: <ul style="list-style-type: none"> • Physician Services • Semi-private room 	100% Coverage \$250 Copayment per admission (waived at UAB)
MATERNITY SERVICES: <ul style="list-style-type: none"> • Physician Services <ul style="list-style-type: none"> • Prenatal, delivery and postnatal care • Maternity Hospitalization 	\$30 Copay per delivery \$250 Copayment per admission (waived at UAB)
EMERGENCY ROOM SERVICES:	\$70 Copayment per visit (waived if admitted within 24 hours)
EMERGENCY AMBULANCE SERVICES: (Must be Medically Necessary)	100% Coverage
DURABLE MEDICAL EQUIPMENT & PROSTHETIC DEVICES:	80% Coverage
SKILLED NURSING FACILITY SERVICES: (Limited to 60 days per Calendar Year)	100% Coverage
DIABETIC SUPPLIES: Insulin covered under CAREMARK Prescription Plan. For Diabetic Supplies call VIVA Health.	100% Coverage
REHABILITATION SERVICES: Physical, Speech, and Occupational Therapy (Requires Prior Authorization from VIVA Health)	\$30 Copayment per visit \$250 Copayment per admission (waived at UAB)
HOME HEALTH CARE SERVICES: (Limited to 60 visits per Calendar Year)	100% Coverage
CHIROPRACTIC SERVICES: (No PCP Referral Required) <ul style="list-style-type: none"> • Treatment for manual manipulation of subluxations only 	\$30 Copayment per visit

TEMPOROMANDIBULAR JOINT DISORDER: (\$3,500 maximum benefit per Lifetime)	\$30 Copayment per visit
SLEEP DISORDERS: (\$3,000 maximum benefit per Lifetime)	\$30 Copayment per visit
TRANSPLANT SERVICES:	100% Coverage after \$250 Hospital Copayment (waived at UAB)
MENTAL HEALTH & SUBSTANCE ABUSE SERVICES*:	
• Inpatient	100% Coverage after \$250 Copayment per admission (waived at UAB)
• Outpatient	\$30 Copayment per visit
*Residential treatment and certain diagnoses are excluded. See your Certificate of Coverage for details.	
COVERED PRESCRIPTION DRUGS*	
• Generic Drugs	
• From a Participating Pharmacy	\$15 Copayment per 31-day supply*
• Mail-order	\$30 Copayment per 90-day supply *
• Preferred Brand Drugs	
• From a Participating Pharmacy	\$35 Copayment per 31-day supply*
• Mail-order	\$88 Copayment per 90-day supply*
• Non-Preferred Brand Drugs	
• From a Participating Pharmacy	\$60 Copayment per 31-day supply*
• Mail-order	\$150 Copayment per 90-day supply*
<i>When generic is available, Member pays difference between generic and brand name price, plus Copayment.</i>	
• Biological Drugs, Biotechnical Drugs and Specialty Pharmaceuticals 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. These medications are received from CAREMARK and can be ordered by calling 1-800-237-2767. For a full list of the medications in this category, please refer to www.vivahealth.com .	80% Coverage
• Oral Contraceptives	Covered (subject to above Copayments)
*Some medications may require prior authorization from VIVA HEALTH. For further information, please contact Customer Service at the phone number listed below.	
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 Copayments described herein and a \$1,500 maximum 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.
LIFETIME MAXIMUM BENEFIT PER MEMBER	\$1,000,000

VIVA HEALTH CUSTOMER SERVICE (205) 558-7474 or 1-800-294-7780
VISIT OUR WEBSITE at www.vivahealth.com

Pre-Existing Condition Policy: No waiting period for pre-existing conditions.

Eligible Dependent: Employee's lawful spouse and unmarried children of eligible employees, under age 19 (or dependent limiting age of 19 up to age 26 if a full-time student in an accredited institution) and handicapped dependents who meet eligibility criteria.