

The Plan's services and benefits, with its copayments/coinsurance 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
<b>CALENDAR YEAR DEDUCTIBLE:</b> 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
<b>COINSURANCE LIMIT:</b> Applies only to out-of-pocket costs on those benefits that are subject to the deductible and require the member to pay a percentage of the cost. The deductible does not count toward the Coinsurance Limit. Does not apply to benefits with a copayment or prescription benefits. Does not apply to Mental Health benefits or Biological, Biotechnical and Specialty Pharmaceuticals which have the separate coinsurance limits listed below.	\$1,500 per individual; \$4,500 aggregate amount per family per Calendar Year
<b>PRIMARY CARE SERVICES:</b> <ul style="list-style-type: none"> <li>• <b>Preventive Care &amp; Other Office Visits</b> <ul style="list-style-type: none"> <li>◆ Routine Physicals (one per Calendar Year)</li> <li>◆ Covered Immunizations</li> <li>◆ Hearing Exams</li> <li>◆ Surgical and Medical Physician Services</li> <li>◆ X-Rays and Laboratory Procedures</li> <li>◆ Illness and Injury</li> </ul> </li> </ul>	100% after \$20 Copayment per visit
<b>SPECIALTY CARE:</b> (No PCP Referral Required) <ul style="list-style-type: none"> <li>• <b>Surgical &amp; Medical Physician Services</b></li> <li>• <b>X-Ray and Laboratory Procedures</b></li> <li>• <b>Ob/Gyn Services</b> (One Ob/Gyn Preventive Visit every Calendar Year)</li> </ul>	100% after \$35 Copayment per visit 100% Coverage 100% after \$35 Copayment per visit
<b>VISION CARE:</b> (No PCP Referral Required) <ul style="list-style-type: none"> <li>• <b>One routine vision exam per Calendar Year</b></li> <li>• <b>Other eye care office visits</b></li> </ul>	100% after \$35 Copayment per visit 100% after \$35 Copayment per visit
<b>ALLERGY SERVICES:</b> (No PCP Referral Required) <ul style="list-style-type: none"> <li>• <b>Physician Services</b></li> <li>• <b>Testing</b></li> </ul>	100% after \$35 Copayment per visit 90% Coverage; subject to deductible and coinsurance limit
<b>DIAGNOSTIC SERVICES:</b> (Including but not limited to CT Scan, MRI, PET/SPECT, ERCP)	90% Coverage; subject to deductible and coinsurance limit
<b>HOSPITAL SERVICES</b> (Does not include Maternity, Rehabilitation or Mental Health. See those categories below): <ul style="list-style-type: none"> <li>• <b>Inpatient Services</b></li> <li>• <b>Outpatient Services</b></li> </ul>	90% Coverage; subject to deductible and coinsurance limit 90% Coverage; subject to deductible and coinsurance limit
<b>MATERNITY SERVICES:</b> <ul style="list-style-type: none"> <li>• <b>Physician Services</b> Prenatal, delivery and postnatal care</li> <li>• <b>Maternity Hospitalization</b></li> </ul>	\$35 Copayment per delivery 90% Coverage; subject to deductible and coinsurance limit
<b>EMERGENCY ROOM SERVICES:</b>	\$125 Copayment per visit (Copoly waived if admitted through ER)
<b>EMERGENCY AMBULANCE SERVICES:</b>	90% Coverage; subject to deductible and coinsurance limit
<b>DURABLE MEDICAL EQUIPMENT &amp; PROSTHETIC DEVICES:</b> (Maximum Benefit of \$15,000 per Lifetime)	90% Coverage; subject to deductible and coinsurance limit
<b>SKILLED NURSING FACILITY SERVICES:</b> (100 Days per Lifetime)	90% Coverage; subject to deductible and coinsurance limit
<b>DIABETIC SUPPLIES:</b> Insulin covered under prescription drug rider. For Diabetic Supplies call VIVA Health.	90% Coverage; subject to deductible and coinsurance limit

<b>REHABILITATION SERVICES: Physical, Speech, and Occupational Therapy</b> (Limited to 60 Total Inpatient Days and 20 Total Outpatient Visits per Calendar Year)	90% Coverage; subject to deductible and coinsurance limit
<b>HOME HEALTH CARE SERVICES:</b> (Limited to 60 Visits per Calendar Year)	90% Coverage; subject to deductible and coinsurance limit
<b>CHIROPRACTIC SERVICES:</b> <i>(No PCP Referral Required)</i> (Covered up to 20 Visits per Calendar Year) • <b>Treatment for manual manipulation of subluxations only</b>	100% after \$35 Copayment per visit
<b>TEMPOROMANDIBULAR JOINT DISORDER:</b> (\$2,000 Maximum Benefit per Lifetime)	100% after \$35 Copayment per visit
<b>SLEEP DISORDERS:</b> \$3,000 Maximum Benefit per Lifetime • Sleep Study <i>(One Sleep Study per Lifetime)</i>	100% after \$35 Copayment per visit 90% Coverage; subject to deductible and coinsurance limit
<b>TRANSPLANT SERVICES:</b>	90% Coverage; subject to deductible and coinsurance limit
<b>MENTAL HEALTH SERVICES:</b> (There is a member out of pocket maximum of \$1,500 per member per Calendar Year)  ◆ Inpatient ◆ Outpatient  Partial or day hospitalization, intensive outpatient treatment, and treatment at a residential facility are not covered services. Certain diagnoses are excluded from coverage. See the Certificate of Coverage for details.	90% Coverage 100% after \$35 Copayment per visit
<b>COVERED PRESCRIPTION DRUGS:</b> (Limited to \$3,000 per Member per Calendar Year) • <b>Generic Drugs</b> ◆ From a Participating Pharmacy ◆ Mail-order • <b>Preferred Brand-Name Drugs</b> ◆ From a Participating Pharmacy ◆ Mail-order • <b>Non-Preferred Brand-Name Drugs</b> ◆ From a Participating Pharmacy ◆ Mail-order  <b>Biological Drugs, Biotechnical Drugs, and Specialty Pharmaceuticals</b> The Prescription coverage limit does not apply. Administered in the home, physician's office or on an outpatient basis. There is a member out of pocket maximum of \$10,000 per member per Calendar Year for biological, biotechnical drugs and specialty pharmaceuticals. These drugs must be obtained from VIVA Health's specialized pharmacy provider. For a listing of these drugs, see our website at <a href="http://www.vivahealth.com">www.vivahealth.com</a> .  Some medications may require prior authorization from VIVA HEALTH. For further information, please contact Customer Service at the phone number listed below.	\$15 Copayment per 31-day supply \$38 Copayment per 90-day supply  \$35 Copayment per 31-day supply \$88 Copayment per 90-day supply  \$60 Copayment per 31-day supply \$150 Copayment per 90-day supply  90% Coverage  <i>When Generic is available, Member pays difference between Generic and Brand-Name price, plus Copayment</i>
<b>Lifetime maximum benefit per member:</b>	<b>\$1,000,000</b>

**VIVA HEALTH CUSTOMER SERVICE (205) 558-7474 or (800) 294-7780**  
**VISIT OUR WEBSITE at [www.vivahealth.com](http://www.vivahealth.com)**

<b>Eligible Dependent:</b>	Employee's lawful spouse and unmarried children of eligible employees under age 19 up to age 25 if a full-time student in an accredited institution or handicapped dependents who meet eligibility criteria. Dependents with a last name different from employee's must be verified as eligible through submission of a marriage or birth certificate with the enrollment application.
<b>Pre-Existing Condition Policy:</b>	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 of 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 if the 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.