SG 80

VIVA HEALTH

Attachment A to Certificate of Coverage

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
CALENDAR YEAR DEDUCTIBLE: The family deductible is $1,500 not to exceed $500 per any individual. Applies ONLY to those benefits with 80% Coverage.	$500 per individual; $1,500 aggregate amount per family
COINSURANCE LIMIT: 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.	$2,000 per individual; $6,000 aggregate amount per family per Calendar Year
PRIMARY CARE SERVICES: • **Preventive Care & Other Office Visits** ♦ *Routine Physicals (one per Calendar Year)* ♦ *Covered Immunizations* ♦ *Hearing Exams* ♦ *Surgical and Medical Physician Services* ♦ *X-Rays and Laboratory Procedures* ♦ *Illness and Injury*	 100% after $25 Copayment per visit
SPECIALTY CARE: *(No PCP Referral Required)* • **Surgical & Medical Physician Services** • **X-Ray and Laboratory Procedures** • **Ob/Gyn Services** (One Ob/Gyn Preventive Visit every Calendar Year)	 100% after $40 Copayment per visit 100% Coverage 100% after $40 Copayment per visit
VISION CARE: *(No PCP Referral Required)* • **One routine vision exam per Calendar Year** • **Other eye care office visits**	 100% after $40 Copayment per visit 100% after $40 Copayment per visit
ALLERGY SERVICES: *(No PCP Referral Required)* • **Physician Services** • **Testing**	 100% after $40 Copayment per visit 80% Coverage; subject to deductible and coinsurance limit
DIAGNOSTIC SERVICES: *(Including but not limited to CT Scan, MRI, PET/SPECT, ERCP)*	 80% Coverage; subject to deductible and coinsurance limit
HOSPITAL SERVICES *(Does not include Maternity, Rehabilitation or Mental Health. See those categories below):* • **Inpatient Services** • **Outpatient Services**	 80% Coverage; subject to deductible and coinsurance limit 80% Coverage; subject to deductible and coinsurance limit
MATERNITY SERVICES: • **Physician Services** *Prenatal, delivery and postnatal care* • **Maternity Hospitalization**	 $40 Copayment per delivery 80% Coverage; subject to deductible and coinsurance limit
EMERGENCY ROOM SERVICES:	$150 Copayment per visit *(Copay waived if admitted through ER)*
EMERGENCY AMBULANCE SERVICES:	80% Coverage; subject to deductible and coinsurance limit
DURABLE MEDICAL EQUIPMENT & PROSTHETIC DEVICES: (Maximum Benefit of $15,000 per Lifetime)	80% Coverage; subject to deductible and coinsurance limit
SKILLED NURSING FACILITY SERVICES: (100 Days per Lifetime)	80% Coverage; subject to deductible and coinsurance limit
DIABETIC SUPPLIES: Insulin covered under prescription drug rider. For Diabetic Supplies call VIVA Health.	80% Coverage; subject to deductible and coinsurance limit

REHABILITATION SERVICES: Physical, Speech, and Occupational Therapy (Limited to 60 Total Inpatient Days and 20 Total Outpatient Visits per Calendar Year)	80% Coverage; subject to deductible and coinsurance limit
HOME HEALTH CARE SERVICES: (Limited to 60 Visits per Calendar Year)	80% Coverage; subject to deductible and coinsurance limit
CHIROPRACTIC SERVICES: *(No PCP Referral Required)* (Covered up to 20 Visits per Calendar Year) • **Treatment for manual manipulation of subluxations only**	100% after $40 Copayment per visit
TEMPOROMANDIBULAR JOINT DISORDER: $2,000 Maximum Benefit per Lifetime	100% after $40 Copayment per visit
SLEEP DISORDERS: $3,000 Maximum Benefit per Lifetime • Sleep Study *(One Sleep Study per Lifetime)*	100% after $40 Copayment per visit 80% Coverage; subject to deductible and coinsurance limit
TRANSPLANT SERVICES:	80% Coverage; subject to deductible and coinsurance limit
MENTAL HEALTH SERVICES: (There is a member out of pocket maximum of $2,000 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.	 80% Coverage 100% after $40 Copayment per visit
COVERED PRESCRIPTION DRUGS: (Limited to $3,000 per Member per Calendar Year)	
• **Generic Drugs** ♦ From a Participating Pharmacy ♦ Mail-order	 $15 Copayment per 31-day supply $38 Copayment per 90-day supply
• **Preferred Brand-Name Drugs** ♦ From a Participating Pharmacy ♦ Mail-order	 $35 Copayment per 31-day supply $88 Copayment per 90-day supply
• **Non-Preferred Brand-Name Drugs** ♦ From a Participating Pharmacy ♦ Mail-order	 $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. 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 www.vivahealth.com.	90% 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***
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

Eligible Dependent: 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.

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 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.