

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
PRIMARY CARE SERVICES: <ul style="list-style-type: none"> • Preventive Care & Other Office Visits <ul style="list-style-type: none"> ◆ Routine Physicals (one per Calendar Year) ◆ Covered Immunizations ◆ Hearing Exams ◆ Surgical & Medical Physician Services ◆ X-Rays and Laboratory Procedures ◆ Illness and Injury 	100% after \$30 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 every Calendar Year) 	100% after \$45 Copayment per visit 100% Coverage 100% after \$45 Copayment per visit
VISION CARE: (No PCP Referral Required) <ul style="list-style-type: none"> • One routine vision exam per Calendar Year • Other eye care office visits 	100% after \$45 Copayment per visit 100% after \$45 Copayment per visit
ALLERGY SERVICES: (No PCP Referral Required) <ul style="list-style-type: none"> • Physician Services • Testing 	100% after \$45 Copayment per visit 80% Coverage
DIAGNOSTIC SERVICES: <i>(Including but not limited to CT Scan, MRI, PET/SPECT, ERCP)</i>	100% after \$250 Copayment per service
HOSPITAL SERVICES: <ul style="list-style-type: none"> • Inpatient Services • Outpatient Services 	100% after \$750 Copayment per admission 100% after \$250 Copayment per service
MATERNITY SERVICES: <ul style="list-style-type: none"> • Physician Services <i>Prenatal, delivery and postnatal care</i> • Maternity Hospitalization 	100% Coverage after \$45 Copayment per delivery 100% after \$750 Copayment per admission
EMERGENCY ROOM SERVICES:	100% after \$150 Copayment per visit <i>(Copay waived if admitted through ER)</i>
EMERGENCY AMBULANCE SERVICES:	80% Coverage
DURABLE MEDICAL EQUIPMENT & PROSTHETIC DEVICES: <i>(Maximum Benefit of \$15,000 per Lifetime)</i>	80% Coverage
SKILLED NURSING FACILITY SERVICES: <i>(100 Days per Lifetime)</i>	80% Coverage
DIABETIC SUPPLIES: Insulin covered under prescription drug rider. For Diabetic supplies call VIVA Health.	100% Coverage
REHABILITATION SERVICES: Physical, Speech, and Occupational Therapy <i>(Limited to 60 Total Inpatient Days and 20 Total Outpatient Visits per Calendar Year)</i>	80% Coverage
HOME HEALTH CARE SERVICES: <i>(Limited to 60 Visits per Calendar Year)</i>	80% Coverage
CHIROPRACTIC SERVICES: (No PCP Referral Required) <i>(Covered up to 20 Visits per Calendar Year)</i> <ul style="list-style-type: none"> • Treatment for manual manipulation of subluxations only 	100% after \$45 Copayment per visit

TEMPOROMANDIBULAR JOINT DISORDER: \$2,000 Maximum Benefit per Lifetime	100% after \$45 Copayment per visit
SLEEP DISORDERS: (\$3,000 Maximum Benefit per Lifetime, One Sleep Study per Lifetime)	100% after \$45 Copayment per visit 100% after \$250 copayment per sleep study
TRANSPLANT SERVICES:	100% Coverage after \$750 Hospital Copayment
MENTAL HEALTH SERVICES:	
<ul style="list-style-type: none"> ◆ Inpatient ◆ Outpatient <p>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.</p>	<p>100% Coverage after \$750 Copayment per admission</p> <p>100% after \$45 Copayment per visit</p>
COVERED PRESCRIPTION DRUGS: (Coverage Limited to \$3,000 per Member per Calendar Year)	
<ul style="list-style-type: none"> • Generic Drugs <ul style="list-style-type: none"> ◆ From a Participating Pharmacy ◆ Mail-order • Preferred Brand-Name Drugs <ul style="list-style-type: none"> ◆ From a Participating Pharmacy ◆ Mail-order • Non-Preferred Brand-Name Drugs <ul style="list-style-type: none"> ◆ From a Participating Pharmacy ◆ Mail-order 	<p>\$15 Copayment per 31-day supply \$38 Copayment per 90-day supply</p> <p>\$35 Copayment per 31-day supply \$88 Copayment per 90-day supply</p> <p>\$60 Copayment per 31-day supply \$150 Copayment per 90-day supply</p>
Biological Drugs, Biotechnical Drugs, and Specialty Pharmaceuticals The prescription drug 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.	<i>When Generic is available, Member pays difference between Generic and Brand-Name price, plus Copayment</i>
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.