

The Plan's services and benefits, with its copayments/coinsurances 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
<p>CALENDAR YEAR DEDUCTIBLE: Applies <i>ONLY</i> to those benefits with 90% Coverage. Does not apply to benefits with a copayment or prescription benefits. Does not apply to Biological, Biotechnical and Specialty Pharmaceuticals, Mental Health and Substance Abuse benefits. The family deductible is \$750 not to exceed \$250 per any individual</p>	<p>\$250 per individual; \$750 aggregate amount per family</p>
<p>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 Biological, Biotechnical and Specialty Pharmaceuticals. Does not apply to Mental Health and Substance Abuse benefits. (See these separate coinsurance limits listed below)</p>	<p>\$1,500 per individual; \$4,500 aggregate amount per family</p>
<p>PRIMARY CARE SERVICES:</p> <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 ◆ X-Rays and Laboratory Procedures ◆ Surgical and Medical Physician Services 	<p>100% after \$20 Copayment per visit</p>
<p>SPECIALTY CARE: (No PCP Referral Required)</p> <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) 	<p>100% after \$35 Copayment per visit 100% Coverage 100% after \$35 Copayment per visit</p>
<p>VISION CARE: (No PCP Referral Required)</p> <ul style="list-style-type: none"> • One routine vision exam per Calendar Year • Other eye care office visits 	<p>100% after \$35 Copayment per visit 100% after \$35 Copayment per visit</p>
<p>ALLERGY SERVICES: (No PCP Referral Required)</p> <ul style="list-style-type: none"> • Physician Services • Testing 	<p>100% after \$35 Copayment per visit 90% Coverage; subject to deductible and coinsurance limit</p>
<p>DIAGNOSTIC SERVICES: (Including but not limited to CT Scan, MRI, PET/SPECT, ERCP)</p>	<p>90% Coverage; subject to deductible and coinsurance limit</p>
<p>HOSPITAL SERVICES:</p> <ul style="list-style-type: none"> • Inpatient Services • Outpatient Services 	<p>90% Coverage; subject to deductible and coinsurance limit 90% Coverage; subject to deductible and coinsurance limit</p>
<p>MATERNITY SERVICES:</p> <ul style="list-style-type: none"> • Physician Services Prenatal, delivery and postnatal care • Maternity Hospitalization 	<p>\$35 Copayment per delivery 90% Coverage; subject to deductible and coinsurance limit</p>
<p>EMERGENCY ROOM SERVICES:</p>	<p>100% after \$125 Copayment per visit (Copayment waived if admitted through ER)</p>
<p>EMERGENCY AMBULANCE SERVICES:</p>	<p>90% Coverage; subject to deductible and coinsurance limit</p>
<p>DURABLE MEDICAL EQUIPMENT & PROSTHETIC DEVICES: (Maximum Benefit of \$15,000 per Lifetime)</p>	<p>90% Coverage; subject to deductible and coinsurance limit</p>
<p>SKILLED NURSING FACILITY SERVICES: (100 Days per Lifetime)</p>	<p>90% Coverage; subject to deductible and coinsurance limit</p>

DIABETIC SUPPLIES: Insulin covered under prescription drug rider. For Diabetic supplies call VIVA Health.	90% 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)	90% Coverage; subject to deductible and coinsurance limit
HOME HEALTH CARE SERVICES: (Limited to 60 Visits per Calendar Year)	90% Coverage; subject to deductible and coinsurance limit
CHIROPRACTIC SERVICES: <i>(No PCP Referral Required)</i> (Covered up to 20 Visits per Calendar Year) • Treatment for manual manipulation of subluxations only	100% after \$35 Copayment per visit
TEMPOROMANDIBULAR JOINT DISORDER: \$2,000 Maximum Benefit per Lifetime	100% after \$35 Copayment per visit
SLEEP DISORDERS: \$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
TRANSPLANT SERVICES:	90% Coverage; subject to deductible and coinsurance limit
MENTAL HEALTH & SUBSTANCE ABUSE SERVICES: ◆ 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 (There is a coinsurance limit of \$1500 per member, per calendar year for Mental Health & Substance Abuse benefits.)
COVERED PRESCRIPTION DRUGS: • 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 • Biological Drugs, Biotechnical Drugs, and Specialty Pharmaceuticals 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 . 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>
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 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.