

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

BENEFITS	COVERAGE
<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>◆ X-Rays and Laboratory Procedures</li> <li>◆ Surgical &amp; Medical Physician Services</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 80% Coverage
<b>DIAGNOSTIC SERVICES:</b> <i>(Including but not limited to CT Scan, MRI, PET/SPECT, ERCP)</i>	100% after \$175 Copayment per service
<b>HOSPITAL INPATIENT SERVICES:</b> <ul style="list-style-type: none"> <li>• <b>Inpatient Services</b></li> <li>• <b>Outpatient Services</b></li> </ul>	100% after \$500 Copayment per admission 100% after \$175 Copayment per service
<b>MATERNITY SERVICES:</b> <ul style="list-style-type: none"> <li>• <b>Physician Services</b> <i>Prenatal, delivery and postnatal care</i></li> <li>• <b>Maternity Hospitalization</b></li> </ul>	100% Coverage after \$35 Copayment per delivery 100% after \$500 Copayment per admission
<b>EMERGENCY ROOM SERVICES:</b>	100% after \$125 Copayment per visit <i>(Copayment waived if admitted through ER)</i>
<b>EMERGENCY AMBULANCE SERVICES:</b>	80% Coverage
<b>DURABLE MEDICAL EQUIPMENT &amp; PROSTHETIC DEVICES:</b> <i>(Maximum Benefit of \$15,000 per Lifetime)</i>	80% Coverage
<b>SKILLED NURSING FACILITY SERVICES:</b> (100 Days per Lifetime)	80% Coverage
<b>DIABETIC SUPPLIES:</b> Insulin covered under prescription drug rider. For Diabetic supplies call VIVA Health.	100% Coverage
<b>REHABILITATION SERVICES: Physical, Speech, and Occupational Therapy</b> <i>(Limited to 60 Total Inpatient Days and 20 Total Outpatient Visits per Calendar Year)</i>	80% Coverage
<b>HOME HEALTH CARE SERVICES:</b> <i>(Limited to 60 Visits per Calendar Year)</i>	80% Coverage
<b>CHIROPRACTIC SERVICES:</b> (No PCP Referral Required) <i>(Covered up to 20 Visits per Calendar Year)</i> <ul style="list-style-type: none"> <li>• <b>Treatment for manual manipulation of subluxations only</b></li> </ul>	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	100% after \$35 Copayment per visit 100% after \$175 copayment per sleep study (one sleep study per lifetime)
<b>TRANSPLANT SERVICES:</b>	100% Coverage after \$500 Hospital Copayment
<b>MENTAL HEALTH &amp; SUBSTANCE ABUSE SERVICES:</b>	
◆ Inpatient	100% Coverage after \$500 Copayment per admission
◆ Outpatient	100% after \$35 Copayment per visit
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.	
<b>COVERED PRESCRIPTION DRUGS:</b>	
• <b>Generic Drugs</b>	
◆ From a Participating Pharmacy	\$15 Copayment per 31-day supply
◆ Mail-order	\$38 Copayment per 90-day supply
• <b>Preferred Brand-Name Drugs</b>	
◆ From a Participating Pharmacy	\$35 Copayment per 31-day supply
◆ Mail-order	\$88 Copayment per 90-day supply
• <b>Non-Preferred Brand-Name Drugs</b>	
◆ From a Participating Pharmacy	\$60 Copayment per 31-day supply
◆ Mail-order	\$150 Copayment per 90-day supply
• <b>Biological Drugs, Biotechnical Drugs, and Specialty Pharmaceuticals</b>	90% Coverage
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 <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.	
	<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)**

**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.