VIVA HEALTH

VIVA 90 WELLNESS

Attachment A to Certificate of Coverage. *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
CALENDAR YEAR DEDUCTIBLE: *Applies ONLY to those benefits with 90% Coverage. Does not apply to benefits with a copayment or prescription benefits. Does not apply to Mental Health or Biological, Biotechnical and Specialty Pharmaceuticals. The family deductible is $900 not to exceed $300 per any individual.*	$300 per individual; $900 aggregate amount per family
COINSURANCE LIMIT: *Applies only to out-of-pocket costs on those benefits that require the member to pay a percentage of the cost, except Biological, Biotechnical and Specialty Pharmaceuticals, which have a separate coinsurance limit listed below. The deductible does not count toward the Coinsurance Limit. Does not apply to benefits with a copayment or prescription benefits.*	$1,500 per individual; $4,500 aggregate amount per family per Calendar Year
PREVENTIVE CARE: • **Well Baby Care (Children under age 3)** • **Routine Physicals (One per Calendar Year for ages 3+)** • **Covered Immunizations** • **OB/GYN Preventive Visit (One per Calendar Year)** • **Other preventive items and services. See Certificate of Coverage for recommendations and guidelines.**	100% Coverage
OTHER PRIMARY CARE SERVICES: • **Surgical and Medical Physician Services** • **Hearing Exams** • **Illness and Injury** • **X-Rays and Laboratory Procedures**	100% after $25 Physician 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 90% Coverage; subject to deductible and coinsurance limit
DIAGNOSTIC SERVICES: *(Including but not limited to CT Scan, MRI, PET/SPECT, ERCP)*	90% Coverage; subject to deductible and coinsurance limit
HOSPITAL SERVICES • **Inpatient Services** • **Outpatient Services**	 90% Coverage; subject to deductible and coinsurance limit 90% Coverage; subject to deductible and coinsurance limit
MATERNITY SERVICES: • **Physician Services** *Prenatal, delivery and postnatal care* • **Maternity Hospitalization**	 $40 Copayment per delivery 90% Coverage; subject to deductible and coinsurance limit
EMERGENCY ROOM SERVICES:	$175 Copayment per visit *(Copay waived if admitted through ER)*
EMERGENCY AMBULANCE SERVICES:	90% Coverage; subject to deductible and coinsurance limit
DURABLE MEDICAL EQUIPMENT & PROSTHETIC DEVICES: (Maximum Benefit of $15,000 per Lifetime)	90% Coverage; subject to deductible and coinsurance limit
SKILLED NURSING FACILITY SERVICES: (100 Days per Lifetime)	90% Coverage; subject to deductible and coinsurance limit

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 25 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: *(No PCP Referral Required)* (Covered up to 25 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: • Sleep Study *(Two Sleep Studies per member per Lifetime)*	100% after $40 Copayment per visit 90% Coverage; subject to deductible and coinsurance limit
TRANSPLANT SERVICES:	90% Coverage; subject to deductible and coinsurance limit
MENTAL HEALTH SERVICES: ♦ Inpatient ♦ Outpatient	 90% Coverage; subject to coinsurance limit 100% after $40 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.	
COVERED PRESCRIPTION DRUGS:	
• **Preferred Generic Drugs**	
♦ From a Participating Pharmacy	$5 Copayment per 31-day supply
♦ Mail-order	$12 Copayment per 90-day supply
♦ Participating Pharmacy	$15 Copayment per 90-day supply
• **Generic Drugs**	
♦ From a Participating Pharmacy	$20 Copayment per 31-day supply
♦ Mail-order	$43 Copayment per 90-day supply
♦ Participating Pharmacy	$60 Copayment per 90-day supply
• **Preferred Brand-Name Drugs**	
♦ From a Participating Pharmacy	$40 Copayment per 31-day supply
♦ Mail-order	$86 Copayment per 90-day supply
♦ Participating Pharmacy	$120 Copayment per 90-day supply
• **Non-Preferred Brand-Name Drugs**	
♦ From a Participating Pharmacy	$65 Copayment per 31-day supply
♦ Mail-order	$162 Copayment per 90-day supply
♦ Participating Pharmacy	$195 Copayment per 90-day supply
Biological Drugs, Biotechnical Drugs, and Specialty Pharmaceuticals Administered in the home, physician's office or on an outpatient basis. There is a Member coinsurance limit 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.
Check with your participating pharmacy to learn if it offers a 90-day supply at retail.

VIVA HEALTH CUSTOMER SERVICE (205) 558-7474 or (800) 294-7780
VISIT OUR WEBSITE at www.vivahealth.com

Eligible Dependent: Eligible Employee's lawful spouse and children of Eligible Employee under age 26 or disabled 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: Except for children under 19, 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 or 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.