VIVA HEALTH

VIVA PLATINUM WELLNESS

Attachment A to Certificate of Coverage

The Plan's services and benefits, with their copayments, coinsurance, and some of the limitations, are listed below. Please remember that this is only a brief listing. For further information, plan guidelines, and exclusions, 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 $600 not to exceed $200 per any individual.	$200 per individual; $600 aggregate amount per family
CALENDAR YEAR OUT-OF-POCKET MAXIMUM: The most a Member will pay per Calendar Year for qualified medical, mental and substance abuse services. The maximum includes deductibles, copayments and coinsurance paid by the Member for qualified services but does not include premiums or prescription drugs. See the Certificate of Coverage for details.	$2,000 per individual; $6,000 per family
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-Ray and Laboratory Procedures	$ 25 Copayment per visit
SPECIALTY CARE: *(No PCP Referral Required)* • Surgical and Medical Physician Services • OB/GYN Services	$40 Copayment per visit $40 Copayment per visit
PEDIATRIC VISION CARE: *(Covered for children ages 0 until age 19; No PCP Referral Required)* • One routine vision exam per plan year for children ages 0 until age 19 • Contacts or one pair of eyeglasses per plan year for children ages 0 until age 19	100% Coverage 100% Coverage
These benefits are administered by VSP. Children must use VSP Advantage providers for routine eye exam and eyewear. Covered eyewear selected by VSP. Find VSP providers at www.vsp.com/advantage or call 855-868-4561. See Attachment C for more information.	
PEDIATRIC DENTAL CARE: *(Covered for children ages 0 until age 19)*	Pediatric dental benefits provided by **Delta Dental PPO**. For more information, go to www.deltadentalins.com/vivaehb or call 800-471-8148
ALLERGY SERVICES: *(No PCP Referral Required)* • Physician Services • Testing	$40 Copayment per visit 90% Coverage
DIAGNOSTIC SERVICES: *(Including but not limited to CT Scan, MRI, PET/SPECT, ERCP)*	$200 Copayment
OUTPATIENT SERVICES: • Surgery and Other Outpatient Services	$200 Copayment per service
HOSPITAL INPATIENT SERVICES: • Physician Services • Semi-Private Room	100% Coverage $200 Copayment per day (Days 1-5)
MATERNITY SERVICES: • Physician Services *(Prenatal, delivery, and postnatal care)* • Maternity Hospitalization • **Newborn care and other services covered only for enrolled child of employee or employee's spouse.** Eligible child must be enrolled within 30 days of birth or adoption. No coverage for children of employee's dependent child.	$40 Copayment per delivery $200 Copayment per day (Days 1-5)
EMERGENCY ROOM SERVICES:	$200 Copayment per visit
EMERGENCY AMBULANCE SERVICES: *(Must be Medically Necessary)*	90% Coverage
DURABLE MEDICAL EQUIPMENT AND PROSTHETIC DEVICES:	90% Coverage
SKILLED NURSING FACILITY SERVICES: *(100 days per Lifetime)*	90% Coverage
DIABETIC SUPPLIES: Insulin covered under prescription drug rider. For Diabetic Supplies call VIVA HEALTH.	90% Coverage
REHABILITIATION SERVICES: Physical, Speech, and Occupational Therapy *(Limited to 60 total inpatient days and 25 total outpatient visits per Calendar Year)*	90% Coverage
HOME HEALTH CARE SERVICES: *(Limited to 60 visits per Calendar Year)*	90% Coverage

VIVA HEALTH

VIVA PLATINUM WELLNESS

Attachment A to Certificate of Coverage

BENEFITS	COVERAGE
CHIROPRACTIC SERVICES: *(No PCP Referral Required. Covered up to 25 visits per Calendar Year)* • Treatment for manual manipulation of subluxations only	$40 copayment per visit
TEMPOROMANDIBULAR JOINT DISORDER: *($2,000 maximum benefit per Lifetime)*	$40 Copayment per visit
SLEEP DISORDERS: *(Two Sleep Studies per Lifetime)*	$40 Copayment per visit $200 Copayment per sleep study
TRANSPLANT SERVICES:	$200 Hospital Copayment per day (Days 1-5)
MENTAL HEALTH & SUBSTANCE ABUSE SERVICES[1]:	
• **Inpatient**	$200 Copayment per day (Days 1-5)
• **Outpatient**	$40 Copayment per visit

[1]Treatment at a residential facility is not a covered service. Certain diagnoses are excluded from coverage. See your Certificate of Coverage for details.

COVERED PRESCRIPTION DRUGS[2]:	
• **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
• **Oral Contraceptives**	$0 Copayment for generic drugs; Applicable Copayment for brand-name drugs
• **Biological Drugs, Biotechnical Drugs, and Specialty Pharmaceuticals** May be administered in the home, physician's office or on an outpatient basis. There is a Calendar Year out-of-pocket maximum of $6,350 per Member or $12,700 per family for biological, biotechnical drugs and specialty pharmaceuticals. When these medications are received from CAREMARK, they must be ordered by calling 1-800-237-2767. For a list of medications in this category, please refer to http://www.vivaemployer.com/Members/Default.aspx.	90% Coverage

[2]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 is eligible to offer a 90-day supply at retail.

VIVA HEALTH Customer Service: (205) 558-7474 or 1-800-294-7780
Visit our Website at www.vivahealth.com

Pre-Existing Condition Policy: No pre-existing condition exclusions or waiting period.

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.