VIVA HEALTH

University of South Alabama

Effective Dates: January 1, 2020 – December 31, 2020

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 Summary Plan Description. As a member of this plan, you have a limited provider network that includes the physicians associated with the University of South Alabama Health System. It also includes access to the entire VIVA HEALTH network of ear, nose, and throat (ENT), ophthalmology, optometry, podiatry, chiropractic, pain management, allergy and immunology, mental health and substance use providers, durable medical equipment, ancillary services, and select additional urgent care providers. These providers can be found in our provider directory, by calling Member Services, or by using our online provider search.

Please keep this Attachment A for your records.

MEDICAL BENEFITS	COVERAGE
CALENDAR YEAR OUT-OF-POCKET MAXIMUM: The most a Member will pay per Calendar Year for qualified medical, mental, and substance use services, prescription drugs, and specialty drugs. The maximum includes deductibles, copayments, and coinsurance paid by the Member for qualified services but does not include premiums, ancillary charges, or out-of-network charges over the Allowed Amount. See the Summary Plan Description for details.	**COVERAGE:** / **INDIVIDUAL** / **FAMILY** MEDICAL: $ 1,850 / $ 3,700 PHARMACY: $ 5,000 / $ 10,000 **TOTAL: $ 6,850 / $ 13,700**
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) • **Preventive Prenatal Care** (As defined in the Summary Plan Description) • **Other preventive items and services** (See the Summary Plan Description for more information)	$0 Copayment per visit
OTHER PRIMARY CARE SERVICES: • **Medical Physician Services** • **Illness and Injury** • **Hearing Exams** • **X-Ray and Laboratory Procedures**	$0 Copayment per visit
SPECIALTY CARE: • **Medical Physician Services** • **Illness and Injury** • **OB/GYN Services** • **X-Ray and Laboratory Procedures**	$0 Copayment per visit
URGENT CARE CENTER SERVICES[1]: • **Medical Physician Services** • **Illness and Injury**	$0 Copayment per visit
[1]In Mobile and Baldwin counties, urgent care services are covered only at Greater Mobile Urgent Care and American Family Care. Outside of Mobile and Baldwin counties, services are covered at any urgent care facility if care is for Urgently Needed Services.	
TELADOC TELEHEALTH SERVICES:	$0 Copayment per consultation
VISION CARE: • **One routine vision exam per Calendar Year** • **Other eye care office visits**	$0 Copayment per visit
ALLERGY SERVICES: • **Physician Services** • **Testing & Treatment**	$0 Copayment per service
DIAGNOSTIC SERVICES: *(Including but not limited to CT Scan, MRI, PET/SPECT, ERCP)*	$0 Copayment per service
OUTPATIENT SERVICES: • **Surgery and Other Outpatient Services**	$0 Copayment per service
HOSPITAL INPATIENT SERVICES: • **Physician Services** • **Semi-Private Room**	$0 Copayment per service
MATERNITY SERVICES: • **Physician Services** (Prenatal, delivery, and postnatal care) • **Maternity Hospitalization**	$0 Copayment per service
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.	
EMERGENCY ROOM SERVICES: Must be Medically Necessary to be covered at 100%. Members can use participating urgent care facilities in urgent but non-emergency situations.	$0 Copayment per service
EMERGENCY AMBULANCE SERVICES: *(Must be Medically Necessary)*	80% Coverage
DURABLE MEDICAL EQUIPMENT AND PROSTHETIC DEVICES: *(Orthotic devices limited to two pairs every 12 months)*	$0 Copayment per service
SKILLED NURSING FACILITY SERVICES: *(Limited to 60 days per Calendar Year)*	80% Coverage

VIVA HEALTH

University of South Alabama

Effective Dates: January 1, 2020 – December 31, 2020

Attachment A to Certificate of Coverage

MEDICAL BENEFITS	COVERAGE
DIABETES SELF-MANAGEMENT EDUCATION:	$0 Copayment per visit
DIABETIC SUPPLIES: For Diabetic Supplies call VIVA HEALTH. Injectable and oral diabetic medications covered under prescription drug rider.	$0 Copayment
REHABILITIATION SERVICES: Physical, Speech, and Occupational Therapy *(Limited to 60 visits each per Calendar Year. Cardiac Rehabilitation is limited to 36 visits per episode.)*	$0 Copayment per visit/admission
HABILITIATION SERVICES: Physical, Speech, and Occupational Therapy and Applied Behavior Analysis (ABA) *[Limited to diagnosis of Autism, Autism Spectrum Disorder, or Pervasive Developmental Delay. ABA therapy subject to the following limits: maximum annual benefit of $20,000 (ages 3-9 years), $15,000 (ages 10-13 years), or $10,000 (ages 14-18 years) and a lifetime limit of $230,000.]*	$0 Copayment per visit/admission
HOME HEALTH CARE SERVICES: *(Limited to 60 visits per Calendar Year)*	$0 Copayment per visit
HOSPICE SERVICES: *(Limited to 180 days per lifetime)*	$0 Copayment per visit
CHIROPRACTIC SERVICES: *(Limited to 60 visits per Calendar Year)*	$0 Copayment per visit
TEMPOROMANDIBULAR JOINT DISORDER (TMJ) PHASE I TREATMENT:	$0 Copayment per service
SLEEP DISORDERS:	$0 Copayment per visit/service
TRANSPLANT SERVICES:	$0 copayment per service
MENTAL HEALTH & SUBSTANCE USE DISORDER SERVICES[2]: • **Inpatient Services** (limited to 30 days for mental health and 30 days for substance use disorder per calendar year and a lifetime limit of 60 days each) • **Outpatient Services[3]** (limited to 60 combined mental health and substance use disorder outpatient visits per member each year)	$0 Copayment per visit/service

[2]Certain diagnoses are excluded from coverage. Treatment at a residential facility is not a covered service. See your Summary Plan Description for details. [3]Limited to treatment in an outpatient facility or free-standing substance use disorder facility only.

PHARMACEUTICAL BENEFITS

PHARMACY DEDUCTIBLE: Applies to all drugs except for oral contraceptives and other preventive drugs required by the Affordable Care Act. $100 per individual; $300 aggregate amount per family

COVERED PRESCRIPTION DRUGS: Some medications may require prior authorization from VIVA HEALTH and specialty medications may be restricted to purchase from Accredo pharmacy. For further information, please contact VIVA HEALTH Customer Service. When generic is available, Member pays the difference between the generic and brand price ("ancillary charge"), plus Copayment. Ancillary charges do not count toward the out-of-pocket maximum. Check with your participating pharmacy to learn if it is eligible to offer a 90-day supply at retail.

PRESCRIPTION DRUG CARD:

Non-Maintenance Prescriptions
Up to a 30 day supply at retail.

Maintenance Prescriptions up to a 90 day supply; one copay for each 30 day supply.

Mail Order requires only two copays for a 90-day supply with no shipping fee. Additional information may be obtained at 1-800-698-3757 or www.Express-Scripts.com.

Specialty Drugs may be administered in the home, physician's office, or on an outpatient basis. When these medications are received from Express Scripts, they must be ordered by calling 1-800-803-2523.

Benefits are not provided for fertility drugs.

EXPRESS SCRIPTS PARTICIPATING PHARMACY NETWORK:

Each prescription purchased from a Participating Pharmacy will be covered at 100% after the deductible with the following copays:

Tier	Type	Copay per 30 day supply[4]
1	Generic	**$10**
2	Preferred Brand	**$50**
3	Non-Preferred Brand	**$75**
4	Specialty	**50%**

[4]**Out-Of-Pocket Maximum:** The benefit increases to 100% of the Allowed Amount after the annual out-of-pocket maximum is met. The out-of-pocket limit is $5,000 per individual not to exceed $10,000 per family.

Insulin, needles, and syringes purchased on the same day will have one copay; otherwise, each has a separate copay. Diabetic Testing Supplies (OneTouch glucose meters, OneTouch glucose test strips, and any brand of lancets/lancet devices) will be covered at 100%. Contraceptives are covered at 100% for all FDA approved contraceptives prescribed by a physician.

NON-PARTICIPATING PHARMACY:

Not covered. No benefits for prescriptions purchased at a non-Participating Pharmacy. A participating pharmacy is a pharmacy contracted with Express Scripts, Inc.

SMOKING CESSATION PRODUCTS:

100% coverage for up to 12 weeks without prior authorization per calendar year for generic Zyban, generic nicotine patch, gum, and lozenge, and nicotine inhaler or nasal spray. 100% coverage for up to 24 weeks without prior authorization per calendar year for varenicline tartrate (Chantix). Prior authorization must be obtained in order to access additional courses of treatment covered at 100%.

ALLOWED AMOUNT OR ALLOWANCE: The "Allowed Amount" or "Allowance" for all Covered Services is determined by the Claims Administrator. The Claims Administrator relies upon in-network provider negotiated rates to determine the relative value for services. The Allowed Amount may not correspond to the usual or customary charge made by a physician, hospital, dentist or other medical provider or by other physicians and medical providers in any geographic area.

VIVA HEALTH®

University of South Alabama

Effective Dates: January 1, 2020 – December 31, 2020

Attachment A to Certificate of Coverage

DENTAL BENEFITS, Administered by Southland Dental

The Dental Plan allows you to seek treatment from any licensed dentist. Please refer to the Southland Dental Member Handbook for covered benefits, limitations, and exclusions. The Dental Plan is included in the health plan premium for VIVA HEALTH and is administered by Southland Dental. There is no additional cost for this plan. For questions regarding the dental plan please contact **Southland Dental Customer Service at 1-800-476-3010.**

Type I Diagnostic/Preventive Services • Routine oral exams, Fluoride treatments (children under 19), Cleanings, X-Rays (limitations may apply), Sealants, Space Maintainers, and Prophylaxis	100% coverage of Maximum Plan Allowance
Type II Basic Services • Fillings, Surgical Extractions, Palliative Services, General Anesthesia, and Endodontics (root canals)	80% coverage of Maximum Plan Allowance
Type III Major Services • Major Restorative (crowns, bridges, and dentures), Denture Repair, and Periodontics	50% coverage of Maximum Plan Allowance
Maximum Dental Benefit: $1,250 Calendar Year limit for members age 19 and older. No Calendar Year limit for members age 18 and under. $25 per person/$75 per family per calendar year deductible applies to Basic and Major Services. Please refer to the dental schedule of benefits, limitations, and exclusions for full benefit descriptions. Time served on a prior carrier's dental plan with your current employer may be credited toward the Southland Dental plan's waiting periods	

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

Eligible Dependent: To be eligible to enroll as a Covered Dependent, a person must be listed on the enrollment application completed by the Subscriber, reside in the state of Alabama or with the Subscriber (exceptions apply), and meet additional qualifying criteria. For exceptions and additional qualifying criteria, please refer to the Summary Plan Description.

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

Nondiscrimination Notice: VIVA HEALTH complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Language Assistance Services: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-294-7780 (TTY: 711).
注意：如果您使用繁體中文，您可以免費獲得語言援助服務．請致電 1-800-294-7780（TTY：711）.