ADDING YOUR BABY TO YOUR COVERAGE

If you or your spouse give birth to or adopt a child, you have 30 days (or 31, depending on your employer or plan sponsor) from the date of birth, adoption, or placement for adoption to add that child to your health insurance coverage. Check your VIVA HEALTH Certificate of Coverage or with your employer or plan sponsor to determine whether your plan allows 30 or 31 days.

Remember: Only your children are eligible for coverage. The children of your dependent children are not eligible for coverage under your plan unless you or your spouse is the child's court-appointed, legal guardian. To add a new baby or child to your plan, contact your employer or plan sponsor.

WHEN YOU CAN GET CARE FROM OUT-OF-NETWORK PROVIDERS

As a VIVA HEALTH member, you agree to get your health care from doctors, hospitals, and other medical providers who have a contract with us. We call these providers "network providers" or "participating providers." You can search for a network provider at **myvivaprovider.com**. VIVA HEALTH will cover services from out-of-network providers, subject to the prior approval of VIVA HEALTH's medical director, for medically necessary services in the rare case the services are not available from network providers. The only other services covered from out-of-network providers are emergency services anywhere and urgently needed care to treat an unforeseen injury or illness when you are traveling or as required by the federal No Surprises Act.

WHAT DO I DO IF I HAVE A PROBLEM?

If you are experiencing a problem with your coverage, such as a disagreement over how your cost-sharing was applied or if a service was denied, please contact our Customer Service department. If our representatives are unable to resolve the issue to your satisfaction, you can file a complaint verbally or in writing. Our plans have an established procedure for filing a complaint or grievance described in your Certificate of Coverage or Summary Plan Description.

At VIVA HEALTH we pride ourselves on being a local health plan that treats our members with respect and courtesy. We hope you found this information helpful and look forward to serving you.

HOW WE COMMUNICATE WITH OUR MEMBERS

VIVA HEALTH communicates with our members in several ways – you pick what works best for you! Each policy holder is mailed an ID card upon enrollment and periodically thereafter if information changes. Your Certificate of Coverage and other plan materials are available on the VIVA HEALTH plan documents web site or by calling Customer Service and requesting a copy. In addition, for most plans, when we pay a claim we mail you an explanation of benefits (EOB) that tells you what was billed, what VIVA HEALTH paid, and how much you owe. To receive your EOBs electronically or to request or print an ID card, you can log into the member portal. Our website also offers valuable health plan and wellness information.

PREVENTIVE SERVICES & ANNUAL WELLNESS VISIT

VIVA HEALTH covers many preventive services such as physicals, mammograms, flu shots, and routine eye exams. If you are on a "non-grandfathered" plan that covers preventive services at 100%, your annual wellness visit, including an annual well woman visit, is covered at no cost to you. If you get other services during this visit that are not preventive and your doctor bills for a sick visit, your doctor's office copay will apply. For example, if you have flu-like symptoms during your wellness visit and are tested and treated for the flu, you will likely owe cost-sharing for that office visit because you received non-preventive services.

VIVA HEALTH®

WE WANT TO THANK YOU

for choosing VIVA HEALTH and remind you of some important aspects of your health care coverage.

Understanding your benefits can ***save you time and money*** and help ensure your care is covered.

These are just a few highlights, so please review your plan documents for more information.

Helpful Links:

VIVA HEALTH Home Page
www.VivaHealth.com

VIVA HEALTH Provider Search
www.MyVivaProvider.com

VIVA HEALTH Plan Documents
www.VivaHealth.com/group/login

VIVA HEALTH Member Portal
www.VivaMembers.com

VIVA HEALTH Customer Service is available Monday through Friday from 8 a.m. to 5 p.m. by calling 205-558-7474 or toll-free at 1-800-294-7780 (TTY: 711).

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VIVA HEALTH®

Health Benefits FAQ

DO YOU HAVE VIVA HEALTH DRUG COVERAGE?

If you have drug coverage through VIVA HEALTH and you take maintenance medicine for chronic conditions, like diabetes, high blood pressure, or high cholesterol, you may be able to get up to a 90-day supply. This is available at most retail pharmacies and through the mail-order option.

If you choose mail order, you will get up to 90-day supply at a discounted amount, saving you time and money. While you do not get a discount for a 90-day supply at the pharmacy, you have the convenience of fewer trips to the pharmacy.

Not all prescriptions are eligible for a 90-day supply, and any supply over 30 days is subject to the 90-day cost sharing, even if you do not get enough medication to cover 90 days. The way your provider writes the prescription, drug limitations, and manufacturer packaging can limit your ability to get coverage for 90 days.

If you use manufacturer coupons or similar assistance programs, such as those offered by pharmaceutical manufacturers, the portions of your cost sharing paid by the manufacturer may not be applied to your deductible or out-of-pocket maximum. Make sure to let us know if you use cost sharing assistance, manufacturer coupons, or similar assistance programs to cover the cost sharing for covered drugs or covered services by calling us at 205-558-7474 (TTY: 711), Monday -Friday, 8am-5pm.

HOW TO DECIDE BETWEEN THE EMERGENCY DEPARTMENT & URGENT CARE

When you have a sudden health issue that requires immediate attention, it can be difficult to know if going to the nearest emergency department is needed or if a visit to an urgent care facility is more appropriate. Emergency departments are designed to deal with life-threatening and other, very serious situations that require immediate medical attention. Going to an emergency department for treatment of non-emergency conditions or for follow-up care is not covered. Urgent care facilities can address less serious conditions that still require prompt attention when you can't get in to see your Primary Care Physician (PCP). If you are unsure whether your sudden health condition is an emergency, contact your PCP or the physician on-call after hours. If you cannot reach your PCP's office, VIVA HEALTH has an on-call nurse who can assist after hours, available by calling Customer Service. Always call VIVA HEALTH within 24 hours or as soon as reasonably possible after you receive emergency services.

HAVE OTHER COVERAGE BESIDES VIVA HEALTH?

Please notify VIVA HEALTH's Customer Service department if you or one of your family members has active health insurance coverage in addition to VIVA HEALTH, whether from another private insurance company or from another source like Medicare. Call Customer Service to let us know, and we will coordinate the benefits accordingly. It's that simple!

WHEN MEDICARE PAYS FIRST

If you are 65 or older and your employer has fewer than 20 employees, you should strongly consider signing up for Medicare. Group coverage sponsored by employers with fewer than 20 employees pays secondary for members 65 and older. This means if you do not take Medicare when you're eligible, it will be like having very little coverage. The same is true if you are under 65 and disabled and have coverage in a plan sponsored by an employer with fewer than 100 employees. Also, if you are 65 or older and covered by a retiree plan, Medicare is the primary payor, and our payment amounts will assume Medicare paid its share first even if you are not enrolled in Medicare. If you have any questions regarding coordinating coverage between Medicare and your group coverage, please contact VIVA HEALTH Customer Service.

COORDINATING BENEFITS BETWEEN MULTIPLE HEALTH PLANS

Some members have coverage under multiple private plans, such as individual, student, and employer-based coverage. Many times, for example, it is through both their employer and their spouse's employer. This can lead to confusion for members in terms of which carrier is primary (pays benefits first). Here are four rules, in order of priority, for knowing which plan is primary:

1. The plan with no coordination of benefits provision or non-duplication coverage exclusion is always primary. All VIVA HEALTH plans have a coordination of benefits provision.
2. The plan that covers a member as a subscriber (policy holder) is primary.
3. The plan of the parent whose birthday comes first in the calendar year is primary with respect to coverage for enrolled dependent children. There are additional rules for divorced or separated parents. See your Certificate of Coverage or call Customer Service for more information.
4. Finally, if none of the rules above determine the order of benefits, the plan that has covered you the longest is primary.

If you receive primary coverage through a plan other than VIVA HEALTH and you lose that coverage, please notify us, along with any providers whose care you are currently under, about that change in coverage.

IF MY DOCTOR SAYS I NEED IT, DOES THAT MEAN IT IS COVERED?

Like all health plans, VIVA HEALTH does not cover every service a health care provider may recommend. To be covered, services must be medically necessary, included in your Certificate of Coverage, and not in the listing of Plan exclusions. Some services have limits or may require a referral from your PCP or approval by VIVA HEALTH beforehand in order to be covered. The fact that a medical provider performs or prescribes a service or that a service is the only available treatment for a particular medical condition does not mean the service is covered.

VIVA HEALTH does not make treatment decisions, only administrative decisions about the benefits covered under the Plan for payment purposes. The participating provider is responsible for the quality of care a member receives and VIVA HEALTH is not liable for any act or omission of a participating provider.