Employer: VIVA 70 Wellness Plan

Coverage Period: 01/01/2014– 12/31/2014

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Subscriber and Family | **Plan Type:** HMO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.whyviva.com/MemberAccess.aspx or by calling 1-800-294-7780.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$2,000** person/ **$4,000** family; Doesn't apply to preventive care, drugs or benefits with a **copayment**.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services that require you to pay **coinsurance**. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. For medical/mental health **$6,350** person/ **$12,700** family; For specialty prescription drugs, **$6,350** person/ **$12,700** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, health care this plan doesn't cover, and out-of-network expenses for non-emergency and non-urgent services.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See www.myvivaprovider.com **or call 1-800-294-7780** for a list of participating providers.	If you use a participating doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your participating doctor or hospital may use a non-participating **provider** for some services. Plans use the term in-network, **preferred** or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the participating **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

Questions: Call 1-800-294-7780 or visit us at www.vivahealth.com.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-800-294-7780 to request a copy.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$40 copay/visit	Not covered	----------none----------
	Specialist visit	$60 copay/visit	Not covered	----------none----------
	Other practitioner office visit	$60 copay/visit for chiropractor	Not covered	Limited to 25 visits per calendar year and treatment for manual manipulation of subluxations.
	Preventive care/ screening/ immunization	No charge	Not covered	Limited to services recommended by federal preventive guidelines. See plan documents for more information.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	Office visit or facility copay may apply.
	Imaging (CT/PET scans, MRIs)	30% coinsurance/test	Not covered	Certain imaging tests require prior authorization for plan to pay for them. If prior authorization is not obtained, no charges for those services will be covered by the plan.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.vivahealth.com	Preferred generic drugs	$5 copay/prescription (retail); $12 copay/ prescription (mail order)	Not covered	Covers up to a 31-day supply (retail); 90-day supply (mail order). No charge for generic, oral contraceptives.
	Generic drugs	$20 copay/prescription (retail); $43 copay/ prescription (mail order)	Not covered	Covers up to a 31-day supply (retail); 90-day supply (mail order). No charge for generic, oral contraceptives.
	Preferred brand drugs	$60 copay/prescription (retail); $150 copay/ prescription (mail order)	Not covered	Covers up to a 31-day supply (retail); 90-day supply (mail order). If generic is available, you pay the difference between the generic and brand price, plus the copay.
	Non-preferred brand drugs	$80 copay/prescription (retail); $200 copay/ prescription (mail order)	Not covered	Covers up to a 31-day supply (retail); 90-day supply (mail order). If generic is available, you pay the difference between the generic and brand price, plus the copay.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
	Specialty drugs	30% coinsurance	Not covered	Requires prior authorization for plan to pay for drugs. Call 1-800-237-2767. If prior authorization is not obtained, no charges for those services will be covered by the plan.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance/ service	Not covered	Requires prior authorization for plan to pay for outpatient surgery. If prior authorization is not obtained, no charges for those services will be covered by the plan.
	Physician/surgeon fees	30% coinsurance/ service	Not covered	Requires prior authorization for plan to pay for outpatient surgery. If prior authorization is not obtained, no charges for those services will be covered by the plan.
If you need immediate medical attention	Emergency room services	30% coinsurance	30% coinsurance	Limited to emergency medical conditions. Follow-up care is not covered. See plan documents for more information.
	Emergency medical transportation	30% coinsurance	30% coinsurance	Limited to transportation to a hospital.
	Urgent care	$60 copay/visit	$60 copay/visit	Coverage from non-participating providers is limited to care outside the VIVA HEALTH service area and requires prior authorization or a referral from a participating provider. If prior authorization is not obtained, no charges for those services will be covered by the plan.
If you have a hospital stay	Facility fee (e.g., hospital room)	$350 copay/day (Days 1-5)	Not covered except for emergency medical condition	Requires prior authorization for plan to pay for admission except for emergency medical conditions. If prior authorization is not obtained, no charges for those services will be covered by the plan.
	Physician/surgeon fee	No charge	Not covered except for emergency medical condition	Requires prior authorization for plan to pay for admission except for emergency medical conditions. If prior authorization is not obtained, no charges for those services will be covered by the plan.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$60 copay/visit	Not covered	Limited to office visits and certain conditions. See plan documents for more information. Partial Hospitalization and Intensive Outpatient Program services require prior authorization for plan to pay for admission. If prior authorization is not obtained, no charges for those services will be covered by the plan.
	Mental/Behavioral health inpatient services	$350 copay/day (Days 1-5)	Not covered except for emergency medical condition	Limited to hospital inpatient care. Requires authorization for plan to pay for admission. If such authorization is not obtained, no charges for those services will be covered by the plan.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
	Substance use disorder outpatient services	$60 copay/visit	Not covered	Limited to certain conditions and treatment methods. See plan documents for more information. Partial Hospitalization and Intensive Outpatient Program services require prior authorization for plan to pay for admission. If prior authorization is not obtained, no charges for those services will be covered by the plan.
	Substance use disorder inpatient services	$350 copay/day (Days 1-5)	Not covered except for emergency medical condition	Limited to hospital inpatient care. Requires authorization for plan to pay for admission. If such authorization is not obtained, no charges for those services will be covered by the plan.
If you are pregnant	Prenatal and postnatal care	$60 copay/ delivery	Not covered	No coverage for dependent children or surrogate pregnancy.
	Delivery and all inpatient services	$350 copay/day (Days 1-5)	Not covered	No coverage for dependent children or surrogate pregnancy.
If you need help recovering or have other special health needs	Home health care	30% coinsurance	Not covered	Requires prior authorization for plan to pay for care. Limited to 60 visits per calendar year. If prior authorization is not obtained, no charges for those services will be covered by the plan.
	Rehabilitation services	30% coinsurance	Not covered	Requires prior authorization for plan to pay for therapy. Limited to 25 total outpatient visits per calendar year for physical, occupational and speech therapy for rehabilitation and habilitation services combined and 60 inpatient days for rehabilitation. If prior authorization is not obtained, no charges for those services will be covered by the plan.
	Habilitation services	30% coinsurance	Not covered	Requires prior authorization for plan to pay for therapy. Limited to diagnosis of autism or autism spectrum disorder and 25 total outpatient visits per calendar year for physical, occupational and speech therapy for rehabilitation and habilitation services combined. If prior authorization is not obtained, no charges for those services will be covered by the plan.
	Skilled nursing care	30% coinsurance	Not covered	Requires prior authorization for plan to pay for care. Limited to 100 days per lifetime. If prior authorization is not obtained, no charges for those services will be covered by the plan.
	Durable medical equipment	30% coinsurance	Not covered	Requires prior authorization for plan to pay for service. If prior authorization is not obtained, no charges for those services will be covered by the plan.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
	Hospice service	No charge	Not covered	Requires prior authorization for plan to pay for hospice. Limited to 180 days per lifetime. If prior authorization is not obtained, no charges for those services will be covered by the plan.
If your child needs dental or eye care	Eye exam	$60 copay/visit	Not covered	Limited to one routine visit per calendar year and medically necessary visits for illness or injury.
	Glasses	Not covered	Not covered	Excluded service.
	Dental check-up	Not covered	Not covered	Excluded service.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Child)
- Glasses
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care
- Routine eye care
- Routine foot care (Diabetics only)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-294-7780. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: VIVA HEALTH at 1-800-294-7780, the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, and the Alabama Department of Insurance at 334-241-4141.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,960
- **Patient pays** $580

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$430
Coinsurance	$0
Limits or exclusions	$150
Total	**$580**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $2,850
- **Patient pays** $2,550

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$1,270
Copays	$1,200
Coinsurance	$0
Limits or exclusions	$80
Total	**$2,550**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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