

**Effective Dates: Coverage Beginning On or After January 1, 2019**  
**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
<b>PRIMARY CARE SERVICES:</b>	
<ul style="list-style-type: none"> <li>Preventive Care &amp; Other Office Visits               <ul style="list-style-type: none"> <li>Routine Physicals</li> <li>Covered Immunizations</li> <li>Hearing Exams</li> <li>Medical Physician Services</li> <li>X-Rays</li> <li>Illness and Injury</li> </ul> </li> </ul>	\$20 Copayment per visit
<b>SPECIALTY CARE:</b> (PCP Referral Required)	
<ul style="list-style-type: none"> <li>Medical Physician Services</li> <li>X-Rays</li> <li>OB/GYN Services (No PCP Referral Required; One OB/GYN preventive visit every Calendar Year)</li> </ul>	\$20 Copayment per visit 100% Coverage \$20 Copayment per visit
<b>URGENT CARE CENTER SERVICES:</b>	
<ul style="list-style-type: none"> <li>Medical Physician Services</li> <li>Illness and Injury</li> </ul>	\$20 Copayment per visit
<b>TELADOC TELEHEALTH SERVICES:</b>	
	\$45 Copayment per consultation
<b>VISION CARE:</b> (No PCP Referral Required)	
<ul style="list-style-type: none"> <li>One routine vision exam per Calendar Year</li> <li>Other eye care office visits</li> </ul>	\$20 Copayment per visit \$20 Copayment per visit
<b>ALLERGY SERVICES:</b> (PCP Referral Required)	
<ul style="list-style-type: none"> <li>Physician Services</li> <li>Testing</li> </ul>	\$20 Copayment per visit 80% Coverage
<b>LABORATORY PROCEDURES:</b>	
<ul style="list-style-type: none"> <li>Covered Genetic Testing</li> </ul>	\$5 Copayment per test 80% Coverage
<b>DIAGNOSTIC SERVICES:</b> (Including but not limited to CT Scan, MRI, PET/SPECT, ERCP)	
	\$125 Copayment per service
<b>HOSPITAL SERVICES:</b>	
<ul style="list-style-type: none"> <li>Inpatient Services</li> <li>Outpatient Services</li> </ul>	\$125 Copayment per admission \$125 Copayment per service
<b>MATERNITY SERVICES:</b> (Covered for employee and employee's spouse; not covered for dependent children)	
<ul style="list-style-type: none"> <li>Physician Services (Prenatal, delivery and postnatal care)</li> <li>Maternity Hospitalization</li> </ul>	\$20 Copayment per delivery \$125 Copayment per admission
<b>Eligible baby must be enrolled in plan within 30 days of birth or adoption for baby's care to be covered.</b>	
<b>EMERGENCY ROOM SERVICES:</b>	
	\$60 Copayment per visit (Copayment waived if admitted to hospital)
<b>EMERGENCY AMBULANCE SERVICES:</b>	
	80% Coverage
<b>DURABLE MEDICAL EQUIPMENT &amp; PROSTHETIC DEVICES:</b>	
	80% Coverage
<b>SKILLED NURSING FACILITY SERVICES:</b> (100 Days per Lifetime)	
	100% Coverage
<b>DIABETES SELF-MANAGEMENT EDUCATION:</b>	
	\$0 Copayment
<b>DIABETIC SUPPLIES:</b> Insulin covered under prescription drug rider. For Diabetic supplies call VIVA HEALTH.	
	100% Coverage
<b>REHABILITATION SERVICES: Physical, Speech, and Occupational Therapy</b> (Limited to 60 Total Inpatient Days and 25 Total Outpatient Visits per Calendar Year)	
	80% Coverage
<b>HOME HEALTH CARE SERVICES:</b> (Limited to 60 Visits per Calendar Year)	
	100% Coverage
<b>CHIROPRACTIC SERVICES:</b> (PCP Referral Required; Covered up to 25 Visits per Calendar Year)	
	\$20 Copayment per visit
<b>TEMPOROMANDIBULAR JOINT DISORDER:</b> (\$2,000 Maximum Benefit per Lifetime)	
	\$20 Copayment per visit
<b>SLEEP DISORDERS:</b>	
<ul style="list-style-type: none"> <li>Sleep Study (Two Sleep Studies per Member per Lifetime)</li> </ul>	\$20 Copayment per visit \$125 Copayment per sleep study
<b>TRANSPLANT SERVICES:</b>	
	\$125 Hospital Copayment
<b>MENTAL HEALTH SERVICES<sup>1</sup>:</b>	
<ul style="list-style-type: none"> <li>Inpatient Services</li> <li>Outpatient Services</li> </ul>	\$125 Copayment per admission \$20 Copayment per visit

<sup>1</sup>Treatment at a residential facility is not a covered service. Substance abuse services are excluded from coverage. Certain diagnoses are excluded from mental health coverage. See the Certificate of Coverage for details

BENEFITS	COVERAGE
<b>COVERED PRESCRIPTION DRUGS<sup>2</sup>:</b>	
<ul style="list-style-type: none"> <li>• <b>Tier 1 (Preferred Generic Drugs)</b> <ul style="list-style-type: none"> <li>○ From a Participating Pharmacy</li> <li>○ Mail-order</li> <li>○ Participating Pharmacy</li> </ul> </li>   <li>• <b>Tier 2 (Generic Drugs)</b> <ul style="list-style-type: none"> <li>○ From a Participating Pharmacy</li> <li>○ Mail-order</li> <li>○ Participating Pharmacy</li> </ul> </li>   <li>• <b>Tier 3 (Preferred Brand and Non-Preferred Generic Drugs)</b> <ul style="list-style-type: none"> <li>○ From a Participating Pharmacy</li> <li>○ Mail-order</li> <li>○ Participating Pharmacy</li> </ul> </li>   <li>• <b>Tier 4 (Non-Preferred Brand and Non-Preferred Generic Drugs)</b> <ul style="list-style-type: none"> <li>○ From a Participating Pharmacy</li> <li>○ Mail-order</li> <li>○ Participating Pharmacy</li> </ul> </li>   <li>• <b>Tier 5 (Biological Drugs, Biotechnical Drugs, and Specialty Pharmaceuticals<sup>3</sup> and Non-Preferred Drugs)</b></li> </ul>	<p>\$5 Copayment per 31-day supply \$12 Copayment per 90-day supply \$15 Copayment per 90-day supply</p> <p>\$20 Copayment per 31-day supply \$43 Copayment per 90-day supply \$60 Copayment per 90-day supply</p> <p>\$40 Copayment per 31-day supply \$86 Copayment per 90-day supply \$120 Copayment per 90-day supply</p> <p>\$65 Copayment per 31-day supply \$162 Copayment per 90-day supply \$195 Copayment per 90-day supply</p> <p>90% Coverage</p>

<sup>2</sup>Some medications may require prior authorization from VIVA HEALTH. For further information, please contact Customer Service at the phone number listed below. <sup>3</sup>May be administered in the home, physician's office or on an outpatient basis. There is a Member out-of-pocket maximum of \$10,000 per Member per Calendar Year for biological, biotechnical drugs and specialty pharmaceuticals. When these medications are received from Express Scripts, they must be ordered by calling 1-800-803-2523. For a list of medications in this category, please refer to <http://www.vivaemployer.com/Members/Default.aspx>

**When Generic is available, Member pays difference between Generic and brand 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 (800) 294-7780  
VISIT OUR WEBSITE at [www.vivahealth.com](http://www.vivahealth.com)**

- Eligible Dependent:** Eligible Employee's lawful spouse and children of Eligible Employees under age 26 or disabled dependents who meet eligibility criteria. Dependents with a last name different from the employee's must be verified as eligible through submission of a marriage or birth certificate with the enrollment application.
- 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)。

VIVA HEALTH believes this health plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, such as the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, such as the elimination of lifetime limits on the dollar value of essential health benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to VIVA HEALTH Customer Service at (205) 558-7474 or 1-800-294-7780. You may also contact the U.S. Department of Health and Human Services at [www.healthcare.gov](http://www.healthcare.gov). For plans subject to ERISA, you may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). This website has a table summarizing which protections do and do not apply to grandfathered health plans.