

Attachment A to Certificate of Coverage

The Plan's services and benefits, with their copayments, coinsurance, and some of the limitations, are listed below. **Services received in a primary, specialty, or urgent care office may be subject to a copay or coinsurance in addition to the office visit cost-sharing depending on the type of service received.** 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.

MEDICAL BENEFITS	COVERAGE
CALENDAR YEAR DEDUCTIBLE: Applies ONLY to those benefits with coinsurance coverage when the Member pays a set percentage of the cost. Does not apply to benefits with a copayment. Does not apply to Biological, Biotechnical and Specialty Pharmaceuticals ordered through Express Scripts but will apply to such drugs when provided directly by a physician or hospital. The family deductible is \$9,400 not to exceed \$4,700 per any individual. See separate pharmacy deductible on next page.	\$4,700 per individual; \$9,400 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, 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 maximum payment allowance. If you have a non-calendar plan year, the maximum limit may change during the course of a calendar year. If the limit increases with a new plan year, you may owe cost-sharing again up to the amount of the increase even if you reached the limit earlier in the Calendar Year. See the Certificate of Coverage for details.	\$8,150 per individual; \$16,300 per family
PREVENTIVE CARE: <ul style="list-style-type: none"> Well Baby Care (<i>Children under age 3</i>) Routine Physicals (<i>One per Calendar Year for ages 3+</i>) Covered Immunizations OB/GYN Preventive Visit (<i>One per Calendar Year</i>) Other preventive items and services. See Certificate of Coverage for more information 	100% Coverage
OTHER PRIMARY CARE SERVICES: <ul style="list-style-type: none"> Medical Physician Services Hearing Exams Illness and Injury 	\$40 Copayment per visit
SPECIALTY CARE: (<i>No PCP Referral Required</i>) <ul style="list-style-type: none"> Medical Physician Services OB/GYN Services Illness and Injury 	\$60 Copayment per visit
URGENT CARE CENTER SERVICES: <ul style="list-style-type: none"> Medical Physician Services Illness and Injury 	\$60 Copayment per visit
TELADOC TELEHEALTH SERVICES:	\$45 Copayment per consultation
PEDIATRIC VISION CARE: (<i>Covered for children ages 0 until age 19; No PCP Referral Required</i>) <ul style="list-style-type: none"> 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
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 1-855-868-4561. See Attachment C for more information.	
PEDIATRIC DENTAL CARE: (<i>Covered for children ages 0 until age 19</i>) For more information, go to www.deltadentalins.com/vivaehb or call 1-800-471-8148.	Pediatric dental benefits provided by Delta Dental PPO.
ALLERGY SERVICES: (<i>No PCP Referral Required</i>) <ul style="list-style-type: none"> Physician Services Testing and Treatment 	\$60 Copayment per visit 65% Coverage
CHRONIC CARE MAINTENANCE: (<i>Including but not limited to dialysis, radiation therapy, wound care, wound therapy</i>)	65% Coverage
LABORATORY SERVICES: <ul style="list-style-type: none"> Laboratory Procedures and Covered Genetic Testing 	65% Coverage
DIAGNOSTIC SERVICES: <ul style="list-style-type: none"> X-Rays Other Diagnostic Services (<i>Including but not limited to CT Scan, MRI, PET/SPECT, ERCP</i>) 	\$10 Copayment per image 65% Coverage
OUTPATIENT SERVICES: <ul style="list-style-type: none"> Surgery and Other Outpatient Services Outpatient Hospital Observation (no procedure performed) 	65% Coverage \$350 Copayment per day
HOSPITAL INPATIENT SERVICES: <ul style="list-style-type: none"> Physician Services Semi-Private Room 	100% Coverage \$350 Copayment per day (Days 1-5)
MATERNITY SERVICES: <ul style="list-style-type: none"> Physician Services (<i>Prenatal, delivery, and postnatal care</i>) Maternity Hospitalization 	\$60 Copayment per delivery \$350 Copayment per day (Days 1-5)
Newborn care and other services covered <u>only</u> 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:	65% Coverage
EMERGENCY AMBULANCE SERVICES: (<i>Must be Medically Necessary</i>)	65% Coverage
DURABLE MEDICAL EQUIPMENT AND PROSTHETIC DEVICES:	65% Coverage
SKILLED NURSING FACILITY SERVICES: (<i>100 days per Lifetime</i>)	65% Coverage
DIABETES SELF-MANAGEMENT EDUCATION:	\$60 Copayment per visit
DIABETIC SUPPLIES: Insulin covered under prescription drug rider. For Diabetic Supplies call VIVA HEALTH.	65% Coverage

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REHABILITATION SERVICES: Physical, Speech, and Occupational Therapy (Limited to 60 total inpatient days, and 25 total outpatient rehabilitation visits per Calendar Year)	65% Coverage
HABILITATION SERVICES: Physical, Speech, and Occupational Therapy (Limited to a diagnosis of Autism, Autism Spectrum Disorder, or Pervasive Developmental Delay)	65% Coverage
HOME HEALTH CARE SERVICES:	65% Coverage
CHIROPRACTIC SERVICES: (No PCP Referral Required. Covered up to 25 visits per Calendar Year)	\$60 Copayment per visit
TEMPOROMANDIBULAR JOINT DISORDER:	\$60 Copayment per visit
SLEEP DISORDERS:	\$60 Copayment per visit
• Sleep Study	65% Coverage per sleep study
TRANSPLANT SERVICES:	\$350 Hospital Copayment per day (Days 1-5)
MENTAL HEALTH & SUBSTANCE ABUSE SERVICES¹:	
• Inpatient Services	\$350 Copayment per day (Days 1-5)
• Outpatient Services	\$60 Copayment per visit

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

PHARMACEUTICAL BENEFITS	COVERAGE
PHARMACY DEDUCTIBLE: Applies to all drugs except for select generic oral contraceptives and other preventive drugs required by the Affordable Care Act. Deductible must be satisfied before copays apply.	\$100 per individual
COVERED PRESCRIPTION DRUGS²:	
• Tier 1 (Preferred Generic Drugs)	
○ From a Participating Pharmacy	\$15 Copayment per 31-day supply
○ Mail-order	\$38 Copayment per 90-day supply
○ Participating Pharmacy	\$45 Copayment per 90-day supply
• Tier 2 (Non-Preferred Generic Drugs)	
○ From a Participating Pharmacy	\$30 Copayment per 31-day supply
○ Mail-order	\$65 Copayment per 90-day supply
○ Participating Pharmacy	\$90 Copayment per 90-day supply
• Tier 3 (Preferred Brand and Non-Preferred Generic Drugs)	
○ From a Participating Pharmacy	\$65 Copayment per 31-day supply
○ Mail-order	\$163 Copayment per 90-day supply
○ Participating Pharmacy	\$195 Copayment per 90-day supply
• Tier 4 (Non-Preferred Brand and Non-Preferred Generic Drugs)	
○ From a Participating Pharmacy	\$100 Copayment per 31-day supply
○ Mail-order	\$250 Copayment per 90-day supply
○ Participating Pharmacy	\$300 Copayment per 90-day supply
• Tier 5 (Preferred Biological Drugs, Biotechnical Drugs, and Specialty Pharmaceuticals³ and Non-Preferred Drugs)	70% Coverage
• Tier 6 (Biological Drugs, Biotechnical Drugs, and Specialty Pharmaceuticals³ and Non-Preferred Drugs)	65% Coverage
• Oral Contraceptives	\$0 Copayment for select generic drugs; Applicable Copayment for other generic drugs and all brand drugs
• Diabetic Testing Supplies (OneTouch glucose meters, OneTouch glucose test strips, and any brand of lancets/lancet devices)	100% Coverage

²Some medications may require prior authorization from VIVA HEALTH. For further information, please contact Customer Service at the phone number listed below.

³May 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. For a list of medications in this category, please refer to www.vivaemployer.com/Members/Default.aspx.

When generic is available, Member pays difference between 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.

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.
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)。