VIVA HEALTH

VIVA CHOICE

Effective Dates: January 1, 2018 – December 31, 2018

Attachment A to Certificate of Coverage

The Plan's services and benefits, with their 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. This health plan is part of a consumer-driven health plan that pairs the health plan benefits with a health savings account (HSA). Funds distributed into an HSA for use with this health plan, up to the annual contribution limit, are tax-deductible and funds in an HSA grow tax-free. You can withdraw funds from your HSA to pay for qualified medical expenses, like deductibles and coinsurance, without penalty. To be eligible for an HSA you must be covered under a high deductible health plan, among other requirements set forth by the IRS.

Please keep this Attachment A for your records.

BENEFITS	COVERAGE
CALENDAR YEAR DEDUCTIBLE: Applies to all benefits except preventive care services covered at no charge. The family deductible is $2,700 not to exceed $1,350 per any individual.	$1,350 per individual; $2,700 aggregate amount 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 and coinsurance paid by the Member for qualified services but does not include premiums or out-of-network charges over the maximum payment allowance. See the Certificate of Coverage for details. The family out-of-pocket maximum is $7,000 not to exceed $3,500 per any individual.	$3,500 per individual; $7,000 aggregate amount per family
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 Certificate of Coverage) • **Other preventive items and services** (See Certificate of Coverage for more information)	100% Coverage
OTHER PRIMARY CARE SERVICES: • **Medical Physician Services** • **Illness and Injury** • **Hearing Exams** • **X-Ray and Laboratory Procedures** ○ Covered Genetic Testing	90% Coverage
SPECIALTY CARE: *(No PCP Referral Required)* • **Medical Physician Services** • **Illness and Injury** • **OB/GYN Services** • **X-Ray and Laboratory Procedures** ○ Covered Genetic Testing	90% Coverage
URGENT CARE CENTER SERVICES: • **Medical Physician Services** • **Illness and Injury**	90% Coverage
VISION CARE: *(No PCP Referral Required)* • **One routine vision exam per Calendar Year** • **Other eye care office visits**	90% Coverage
ALLERGY SERVICES: *(No PCP Referral Required)* • **Physician Services** • **Testing**	90% Coverage
DIAGNOSTIC SERVICES: *(Including but not limited to CT Scan, MRI, PET/SPECT, ERCP)*	90% Coverage
OUTPATIENT SERVICES: • **Surgery and Other Outpatient Services**	90% Coverage
HOSPITAL INPATIENT SERVICES: • **Physician Services** • **Semi-Private Room**	90% Coverage
MATERNITY SERVICES: *(Covered for employee and employee's spouse; not covered for dependent children except as provided under Preventive Care)* • **Physician Services** (Prenatal, delivery, and postnatal care) • **Maternity Hospitalization** **Eligible baby must be enrolled in plan within 30 days of birth or adoption for baby's care to be covered.**	90% Coverage
EMERGENCY ROOM SERVICES: Members can use participating urgent care facilities in urgent but non-emergency situations	90% Coverage
EMERGENCY AMBULANCE SERVICES: *(Must be Medically Necessary)*	90% Coverage
DURABLE MEDICAL EQUIPMENT AND PROSTHETIC DEVICES:	90% Coverage
SKILLED NURSING FACILITY SERVICES: *(Limited to 60 days per Calendar Year)*	90% Coverage
DIABETES SELF-MANAGEMENT EDUCATION:	90% Coverage
DIABETIC SUPPLIES: Insulin covered under prescription drug rider. For Diabetic Supplies call VIVA HEALTH.	90% Coverage
REHABILITIATION SERVICES: Physical, Speech, and Occupational Therapy	90% Coverage
HABILITATION SERVICES: Physical, Speech, and Occupational Therapy and Applied Behavior Analysis *(limited to a diagnosis of Autism, Autism Spectrum Disorder, or Pervasive Developmental Delay)*	90% Coverage

VIVA HEALTH®

VIVA CHOICE

Effective Dates: January 1, 2018 – December 31, 2018

Attachment A to Certificate of Coverage

BENEFITS	COVERAGE
HOME HEALTH CARE SERVICES: *(Limited to 60 visits per Calendar Year)*	90% Coverage
CHIROPRACTIC SERVICES: *(No PCP Referral Required)*	90% Coverage
TEMPOROMANDIBULAR JOINT DISORDER: *($3,500 maximum benefit per Lifetime)*	90% Coverage
SLEEP DISORDERS: *(2 Sleep Studies per Member per Lifetime)*	90% Coverage
TRANSPLANT SERVICES:	90% Coverage
MENTAL HEALTH & SUBSTANCE ABUSE SERVICES[1]:	
• **Inpatient Services**	90% Coverage
• **Outpatient Services**	
[1]Residential treatment and certain diagnoses are excluded. See your Certificate of Coverage for details.	
COVERED PRESCRIPTION DRUGS[2]:	
• **Generic Drugs**	
○ From a Participating Pharmacy	90% Coverage
○ Mail-order	90% Coverage
○ Participating Pharmacy	90% Coverage
• **Preferred Brand and Non-Preferred Generic Drugs**	
○ From a Participating Pharmacy	90% Coverage
○ Mail-order	90% Coverage
○ Participating Pharmacy	90% Coverage
• **Non-Preferred Brand and Non-Preferred Generic Drugs**	
○ From a Participating Pharmacy	90% Coverage
○ Mail-order	90% Coverage
○ Participating Pharmacy	90% Coverage
• **Biological Drugs, Biotechnical Drugs, and Specialty Pharmaceuticals[3]**	90% Coverage
• **Oral Contraceptives**	$0 Copayment for generic drugs; Applicable Coinsurance for brand-name drugs

[2]Some medications may require prior authorization from VIVA HEALTH. For further information, please contact Customer Service at the phone number listed below. [3]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. 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 Name price.
Check with your participating pharmacy to learn if it is eligible to offer a 90-day supply at retail.

SMOKING CESSATION PRODUCTS: **Two, 12-week treatment courses total per Calendar Year. Prescription required.** [Generic nicotine replacement products (including the patch, lozenge, gum, inhaler, or nasal spray), or Nicotrol (inhaler), or Nicotrol NS (nasal spray), or Generic Zyban, or Varenicline tartrate (Chantix)].	$0 Copayment
DEPENDENT STUDENT BENEFITS: (Emergencies and in-area care are covered under the appropriate sections set forth in the Certificate of Coverage.)	Services to treat an illness or injury for Covered Dependents will be covered while they are full-time students at an accredited educational institution out of the Service Area, subject to the Coinsurance described herein and a $1,500 maximum benefit per Calendar Year.
SABBATICAL: (Sabbatical leave is a period of paid leave granted to faculty members by the Employer to pursue professional development, a program of investigation, creative writing, or artistry, and the like.)	Services to treat an illness or injury for Subscribers and Covered Dependents on Sabbatical Leave will be covered while they are out of the Service Area, subject to the Coinsurance described herein and a $1,500 maximum benefit per Calendar Year.

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

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 Service Area or with the Subscriber (exceptions apply), and meet additional qualifying criteria. For exceptions and additional qualifying criteria, please refer to the Certificate of Coverage.

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).