kennion group: VIVA 200

Effective Dates: Coverage Beginning On or After January 1, 2020

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 MEDICAL DEDUCTIBLE: Applies to those qualified medical services administered by VIVA HEALTH with coinsurance coverage when the Member pays a set percentage of the cost and to those benefits that specify coverage at 100% "after deductible." Does not apply to benefits with a copayment.	$200 per individual; $600 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 administered by VIVA HEALTH. The maximum includes deductibles, copayments, and coinsurance paid by the Member for qualified medical services but does not include premiums, ancillary charges, or out-of-network charges over the maximum payment allowance. Because this is a non-calendar plan year, the maximum limit may change during the course of a calendar year at renewal. 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.	$4,000 per individual; $8,000 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 • OB/GYN Services • Hearing Exams • Illness and Injury	$35 Copayment per visit
SPECIALTY CARE: *(No PCP Referral Required)* • Medical Physician Services • Illness and Injury	$50 Copayment per visit
URGENT CARE CENTER SERVICES: • Medical Physician Services • Illness and Injury	$35 Copayment per visit
TELADOC TELEHEALTH SERVICES:	$0 per consultation
LABORATORY PROCEDURES:	100% Coverage after deductible
ALLERGY SERVICES: *(No PCP Referral Required)* • Physician Services • Testing and Treatment	$50 Copayment per visit 80% Coverage after deductible
OUTPATIENT DIAGNOSTIC SERVICES *(Including, but not limited to, Diagnostic Lab, X-Ray, Pathology, CT Scan, MRI, PET/SPECT, and ERCP)*	100% Coverage after deductible
OUTPATIENT THERAPY SERVICES: *(Including, but not limited to, dialysis, wound therapy, radiation therapy, chemotherapy, and IV therapy)*	100% Coverage after deductible
OUTPATIENT BIOLOGICAL, BIOTECHNICAL, AND SPECIALTY PHARMACEUTICAL MEDICAL BENEFIT: • Administered in a physician's office or outpatient facility	80% Coverage after deductible
OUTPATIENT FACILITY SERVICES: • Physician Services • Surgery and Other Outpatient Facility Services	100% Coverage $200 Copayment per service
HOSPITAL INPATIENT SERVICES: • Physician Services • Semi-Private Room	$150 Copayment per admission plus a $50 Copayment per day (Days 2-6)
MATERNITY SERVICES: *(Covered for employee and employee's spouse; not covered for dependent children except as provided under Preventive Care)* • Prenatal and Postnatal Physician Services • Maternity Hospitalization and Hospital Physician Services (delivery) **Eligible baby must be enrolled in plan within 30 days of birth or adoption for care to be covered.**	$35 Copayment per delivery $150 Copayment per admission plus a $50 Copayment per day (Days 2-6)
EMERGENCY ROOM SERVICES: • Physician Services • Facility Fee	$50 Copayment per visit $200 Copayment per visit
EMERGENCY AMBULANCE SERVICES: *(Must be Medically Necessary)*	80% Coverage after deductible
DURABLE MEDICAL EQUIPMENT AND PROSTHETIC DEVICES:	80% Coverage after deductible

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MEDICAL BENEFITS	COVERAGE
DIABETES SELF-MANAGEMENT EDUCATION:	$50 Copayment per visit
DIABETIC SUPPLIES: For Diabetic Supplies call VIVA HEALTH. Insulin not covered under the medical benefit.	80% Coverage after deductible
REHABILITIATION SERVICES: Physical, Speech, and Occupational Therapy *(Limited to 60 total inpatient days and 30 total outpatient visits per Calendar Year)*	80% Coverage after deductible
HABILITATION SERVICES: *(Limited to a diagnosis of Autism, Autism Spectrum Disorder, or Pervasive Developmental Delay)*	
• Physical, Speech, and Occupational Therapy	80% Coverage after deductible
• Applied Behavioral Analysis (ABA) Therapy	$35 Copayment per visit
HOME HEALTH CARE SERVICES: *(Limited to 60 visits per Calendar Year)*	100% Coverage
SKILLED NURSING FACILITY SERVICES: *(Limited to 100 days per Lifetime)*	100% Coverage
HOSPICE SERVICES:	100% Coverage
CHIROPRACTIC SERVICES: *(No PCP Referral Required. Covered up to 15 visits per Calendar Year)*	80% Coverage after deductible
TEMPOROMANDIBULAR JOINT DISORDER:	$50 Copayment per visit
SLEEP DISORDERS:	$50 Copayment per visit
• Sleep Study	80% Coverage after deductible
TRANSPLANT SERVICES:	
• Inpatient services	$150 Copayment per admission plus a $50 Copayment per day (Days 2-6)
MENTAL HEALTH & SUBSTANCE ABUSE SERVICES[1]:	
• Inpatient Services	$150 Copayment per admission plus a $50 Copayment per day (Days 2-6)
• Outpatient Services	$35 Copayment per visit

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

RETAIL PRESCRIPTION DRUG COVERAGE EXCLUDED

The Alabama Pharmacy Association plan does not include a retail prescription drug program. Any questions regarding retail prescription drugs must be submitted to the Alabama Pharmacy Association rather than to VIVA HEALTH, which administers all other benefits described in this Summary Plan Description.

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

Dependent Student Benefits: 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 Copayments described herein and a $1,500 maximum benefit per calendar year. Emergencies and in-area care are covered under the appropriate sections set forth in the Certificate of Coverage.

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).