kennion group: BASIC GOLD

Effective Dates: Coverage Beginning On or After January 1, 2021

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 benefits 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. 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.	$1,000 per individual; $2,000 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.	$6,000 per individual; $12,000 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 • Hearing Exams • Illness and Injury • X-Rays and Laboratory Procedures	$40 Copayment per visit
SPECIALTY CARE: *(No PCP Referral Required)* • Medical Physician Services • OB/GYN Services • Illness and Injury • X-rays and Laboratory Procedures	$60 Copayment per visit
URGENT CARE CENTER SERVICES: • Medical Physician Services • Illness and Injury	$60 Copayment per visit
ALLERGY SERVICES: *(No PCP Referral Required)* • Physician Services • Testing and Treatment	$60 Copayment per visit 80% Coverage after deductible
DIAGNOSTIC SERVICES: • Outpatient Diagnostic Services *(Including, but not limited to, CT Scan, MRI, PET/SPECT, ERCP, outpatient facility lab, X-Ray, and Pathology)* • Covered Genetic Testing	$250 Copayment per procedure 80% Coverage after deductible
OUTPATIENT THERAPY SERVICES: *(Including dialysis, radiation therapy, chemotherapy, and IV therapy)*	100% Coverage
OUTPATIENT FACILITY SERVICES: • Physician Services • Surgery and Other Outpatient Facility Services	100% Coverage after deductible $250 Copayment per service
HOSPITAL INPATIENT SERVICES: • Physician Services • Semi-Private Room	100% Coverage after deductible $250 Copayment per day (Days 1-5)
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 • Hospital Physician Services (delivery) • Maternity Hospitalization **Eligible baby must be enrolled in plan within 30 days of birth or adoption for care to be covered.**	$60 Copayment per delivery 100% Coverage after deductible $250 Copayment per day (Days 1-5)
EMERGENCY ROOM SERVICES: • Physician Services • Facility Fee	$60 Copayment per visit $250 Copayment per visit
EMERGENCY AMBULANCE SERVICES: *(Must be Medically Necessary)*	80% Coverage after deductible
DURABLE MEDICAL EQUIPMENT AND PROSTHETIC DEVICES:	80% Coverage after deductible
DIABETES SELF-MANAGEMENT EDUCATION:	$60 Copayment per visit
DIABETIC SUPPLIES: Insulin covered under prescription drug rider. For Diabetic Supplies call VIVA HEALTH.	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

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MEDICAL BENEFITS	COVERAGE
HABILITATION SERVICES: Physical, Speech, and Occupational Therapy *(Limited to a diagnosis of Autism, Autism Spectrum Disorder, or Pervasive Developmental Delay)*	80% Coverage after deductible
HOME HEALTH CARE SERVICES: *(Limited to 60 visits per Calendar Year)*	80% Coverage after deductible
SKILLED NURSING FACILITY SERVICES: *(Limited to 100 visits per Lifetime)*	80% Coverage after deductible
HOSPICE SERVICES:	80% Coverage after deductible
CHIROPRACTIC SERVICES: *(No PCP Referral Required. Covered up to 15 visits per Calendar Year)*	$60 Copayment per visit
TEMPOROMANDIBULAR JOINT DISORDER:	$60 Copayment per visit
SLEEP DISORDERS:	$60 Copayment per visit
• Sleep Study	80% Coverage after deductible
TRANSPLANT SERVICES:	
• Inpatient Physician Services	100% Coverage after deductible
• Semi-Private Room	$250 Copayment per day (Days 1-5)
MENTAL HEALTH & SUBSTANCE ABUSE SERVICES[1]:	
• Inpatient Physician Services	100% Coverage after deductible
• Inpatient Facility Services	$250 Copayment per day (Days 1-5)
• Outpatient Services	$60 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.

PHARMACEUTICAL BENEFITS	COVERAGE
CALENDAR YEAR PHARMACY DEDUCTIBLE: Applies ONLY to those drugs with coinsurance coverage when the Member pays a set percentage of the cost (Biological, Biotechnical and Specialty Pharmaceuticals ordered through Express Scripts). Does not apply to drugs with a copayment. Does not apply to preventive drugs required by the Affordable Care Act. Deductible must be satisfied before coinsurance applies.	$1,000 per individual; $2,000 per family
COVERED PRESCRIPTION DRUGS[2]:	
• **Tier 1 (Generic Drugs)**	
○ From a Participating Pharmacy	$15 Copayment per 30-day supply
○ Mail-order	$37.50 Copayment per 90-day supply
○ Participating Pharmacy	$45 Copayment per 90-day supply
• **Tier 2 (Preferred Brand and Non-Preferred Generic Drugs)**	
○ From a Participating Pharmacy	$50 Copayment per 30-day supply
○ Mail-order	$125 Copayment per 90-day supply
○ Participating Pharmacy	$150 Copayment per 90-day supply
• **Tier 3 (Non-Preferred Brand and Non-Preferred Generic Drugs)**	
○ From a Participating Pharmacy	$100 Copayment per 30-day supply
○ Mail-order	$250 Copayment per 90-day supply
○ Participating Pharmacy	$300 Copayment per 90-day supply
• **Tier 4 (Biological Drugs, Biotechnical Drugs, and Specialty Pharmaceuticals[3] and Non-Preferred Drugs)**	50% Coverage after deductible
• **Oral Contraceptives**	$0 Copayment for select generic drugs; Applicable Copayment for other generic drugs and all brand drugs
• **Diabetic Testing Supplies [OneTouch and Freestyle (excluding *Libre*) glucose meters, OneTouch and Freestyle glucose test strips, and any brand of lancets/lancet devices]**	100% Coverage

[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 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

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).