kennion group: SAVER HSA

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. This health plan is eligible to pair 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, such as this, among other requirements set forth by the IRS. 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 all benefits except for preventive care services covered at no charge.	$6,450 per individual; $12,900 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.	$6,450 per individual; $12,900 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-Ray and Laboratory Procedures ○ Covered Genetic Testing	100% Coverage after deductible
SPECIALTY CARE: *(No PCP Referral Required)* • Medical Physician Services • OB/GYN Services • Illness and Injury • X-Ray and Laboratory Procedures ○ Covered Genetic Testing	100% Coverage after deductible
URGENT CARE CENTER SERVICES: • Medical Physician Services • Illness and Injury	100% Coverage after deductible
ALLERGY SERVICES: *(No PCP Referral Required)* • Physician Services • Testing and treatment	100% Coverage after deductible
DIAGNOSTIC SERVICES: *(Including, but not limited to, CT Scan, MRI, PET/SPECT, ERCP, outpatient facility lab, X-Ray, and pathology)*	100% Coverage after deductible
OUTPATIENT THERAPY SERVICES: *(Including dialysis, radiation therapy, chemotherapy, and IV therapy)*	100% Coverage after deductible
OUTPATIENT FACILITY SERVICES: • Physician Services • Surgery and Other Outpatient Facility Services	100% Coverage after deductible
HOSPITAL INPATIENT SERVICES: • Physician Services • Semi-Private Room	100% Coverage after deductible
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.**	100% Coverage after deductible
EMERGENCY ROOM SERVICES: • Physician Services • Facility Fee	100% Coverage after deductible
EMERGENCY AMBULANCE SERVICES: *(Must be Medically Necessary)*	100% Coverage after deductible
DURABLE MEDICAL EQUIPMENT AND PROSTHETIC DEVICES:	100% Coverage after deductible
DIABETES SELF-MANAGEMENT EDUCATION:	100% Coverage after deductible

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MEDICAL BENEFITS	COVERAGE
DIABETIC SUPPLIES: Insulin covered under prescription drug rider. For Diabetic Supplies call VIVA HEALTH.	100% Coverage after deductible
REHABILITIATION SERVICES: Physical, Speech, and Occupational Therapy *(Limited to 60 total inpatient days and 30 total outpatient visits per Calendar Year)*	100% Coverage after deductible
HABILITATION SERVICES: Physical, Speech, and Occupational Therapy *(Limited to a diagnosis of Autism, Autism Spectrum Disorder, or Pervasive Developmental Delay)*	100% Coverage after deductible
HOME HEALTH CARE SERVICES: *(Limited to 60 visits per Calendar Year)*	100% Coverage after deductible
SKILLED NURSING FACILITY SERVICES: *(Limited to 100 visits per Lifetime)*	100% Coverage after deductible
HOSPICE SERVICES:	100% Coverage after deductible
CHIROPRACTIC SERVICES: *(No PCP Referral Required. Covered up to 15 visits per Calendar Year)*	100% Coverage after deductible
TEMPOROMANDIBULAR JOINT DISORDER:	100% Coverage after deductible
SLEEP DISORDERS: • Sleep Study	100% Coverage after deductible
TRANSPLANT SERVICES: • Inpatient Physician Services • Semi-Private Room	100% Coverage after deductible
MENTAL HEALTH & SUBSTANCE ABUSE SERVICES[1]: • Inpatient Physician Services • Inpatient Facility Services • Outpatient Services	100% Coverage after deductible

[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
COVERED PRESCRIPTION DRUGS[2]:	
• **Tier 1 (Generic Drugs)**	100% Coverage after deductible
• **Tier 2 (Preferred Brand and Non-Preferred Generic Drugs)**	100% Coverage after deductible
• **Tier 3 (Non-Preferred Brand and Non-Preferred Generic Drugs)**	100% Coverage after deductible
• **Tier 4 (Biological Drugs, Biotechnical Drugs, and Specialty Pharmaceuticals[3] and Non-Preferred Drugs)**	100% 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 Deductible 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).