PECO FOODS: CLASSIC WELLNESS

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 DEDUCTIBLE: Applies ONLY to those benefits with coinsurance coverage when the Member pays a set percentage of the cost and "after deductible" is indicated. 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, prescription, 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.	$1,000 per individual; $3,000 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	80% Coverage after $15 Copayment
SPECIALTY CARE: *(No PCP Referral Required)* • Medical Physician Services • OB/GYN Services • Illness and Injury	80% Coverage after $15 Copayment
URGENT CARE CENTER SERVICES: • Medical Physician Services • Illness and Injury	80% Coverage after $15 Copayment
TELEHEALTH VENDOR SERVICES:	$0 Copayment per consultation
VISION CARE: *(No PCP Referral Required)* • Illness and Injury	80% Coverage after $15 Copayment
ALLERGY SERVICES: *(No PCP Referral Required)* • Physician Services • Testing and Treatment	80% Coverage after $15 Copayment 80% Coverage after deductible
CHRONIC CARE MAINTENANCE: *(Including, but not limited to, dialysis, IV therapy, chemotherapy, radiation therapy, wound care, wound therapy)*	80% Coverage after deductible
DIAGNOSTIC SERVICES: • Laboratory procedures (including covered genetic testing), and X-Rays • Other Diagnostic Services (including, but not limited to, CT Scan, MRI, PET/SPECT, ERCP)	80% Coverage after deductible
OUTPATIENT SERVICES: • Physician Surgery and Other Outpatient Services • Facility Surgery and Other Outpatient Services • Outpatient Hospital Observation (No procedure performed)	80% Coverage 80% Coverage after deductible 80% Coverage after deductible
HOSPITAL INPATIENT SERVICES: • Physician Services • Facility Services	80% Coverage after deductible
MATERNITY SERVICES: • Physician Prenatal and Postnatal Services • Physician Delivery Services • Maternity Hospitalization **Newborn care and other services covered <u>only</u> for enrolled child of employee or employee's spouse. Eligible baby must be enrolled in plan within 30 days of birth or adoption for care to be covered. No coverage for children of employee's dependent child.**	80% Coverage after $15 Copayment 80% Coverage after deductible 80% Coverage after deductible
EMERGENCY ROOM SERVICES: *(Cost sharing waived if admitted within 24 hours)* • Physician Services • Facility Services	80% Coverage after $15 Copayment 80% Coverage after deductible
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:	80% Coverage after $15 Copayment

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MEDICAL BENEFITS	COVERAGE
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
HABILITATION SERVICES: Physical, Speech, and Occupational Therapy and Applied Behavior Analysis (*Limited to a diagnosis of Autism, Autism Spectrum Disorder, or Pervasive Developmental Delay)*	80% Coverage after deductible
SKILLED NURSING FACILITY SERVICES: *(100 days per Lifetime)*	100% Coverage
HOME HEALTH CARE SERVICES: *(Limited to 60 visits per Calendar Year)*	100% Coverage
CHIROPRACTIC SERVICES: *(No PCP Referral Required. Covered up to 25 visits per Calendar Year)*	80% Coverage after $15 Copayment
TEMPOROMANDIBULAR JOINT DISORDER:	80% Coverage after $15 Copayment
SLEEP DISORDERS: • Sleep Study	80% Coverage after $15 Copayment 80% Coverage after deductible per sleep study
TRANSPLANT SERVICES: • Physician Services • Semi-Private Room	80% Coverage after deductible
MENTAL HEALTH & SUBSTANCE ABUSE INPATIENT SERVICES[1]: • Physician Services • Semi-Private Room	80% Coverage after deductible
MENTAL HEALTH & SUBSTANCE ABUSE OUTPATIENT SERVICES[1]: • Outpatient Services *(Including, but not limited to, Intensive Outpatient Services and Partial Hospitalization)*	80% Coverage after $15 Copayment

[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 (Preferred Generic Drugs)**	100% Coverage after deductible
• **Tier 2 (Brand Drugs and Non-Preferred Generic Drugs)**	80% Coverage after deductible
• **Tier 3 (Biological Drugs, Biotechnical Drugs, and Specialty Pharmaceuticals[3] and Non-Preferred Generic Drugs)**	80% Coverage after deductible
• **Select Generic Oral Contraceptives**	100% Coverage[4]
• **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. [4]Applicable Copayment for other generic oral contraceptive drugs and all brand oral contraceptive drugs.

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).