

Attachment A to Certificate of Coverage

The Plan's services and benefits, with their copayments, 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 Summary Plan Description. As a member of this plan, you have a limited provider network that includes the physicians associated with the University of South Alabama Health System. It also includes access to the entire VIVA HEALTH network of dermatology, ear, nose, and throat (ENT), ophthalmology, optometry, podiatry, chiropractic, pain management, allergy, mental health and substance use, endocrinology, urology, rheumatology providers, durable medical equipment, ancillary services, and select additional urgent care providers. These providers can be found in our provider directory, by calling Member Services, or by using our online provider search.

Please keep this Attachment A for your records.

BENEFITS	COVERAGE												
<p>CALENDAR YEAR OUT-OF-POCKET MAXIMUM: The most a Member will pay per Calendar Year for qualified medical, mental, and substance use 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 or out-of-network charges over the Allowed Amount. See the Summary Plan Description for details.</p>	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 30%; text-align: left;">COVERAGE:</th> <th style="width: 35%; text-align: center;">INDIVIDUAL</th> <th style="width: 35%; text-align: center;">FAMILY</th> </tr> </thead> <tbody> <tr> <td>MEDICAL:</td> <td style="text-align: center;">\$ 1,850</td> <td style="text-align: center;">\$ 3,700</td> </tr> <tr> <td>PHARMACY:</td> <td style="text-align: center;">\$ 5,000</td> <td style="text-align: center;">\$ 10,000</td> </tr> <tr> <td>TOTAL:</td> <td style="text-align: center;">\$ 6,850</td> <td style="text-align: center;">\$ 13,700</td> </tr> </tbody> </table>	COVERAGE:	INDIVIDUAL	FAMILY	MEDICAL:	\$ 1,850	\$ 3,700	PHARMACY:	\$ 5,000	\$ 10,000	TOTAL:	\$ 6,850	\$ 13,700
COVERAGE:	INDIVIDUAL	FAMILY											
MEDICAL:	\$ 1,850	\$ 3,700											
PHARMACY:	\$ 5,000	\$ 10,000											
TOTAL:	\$ 6,850	\$ 13,700											
<p>PREVENTIVE CARE:</p> <ul style="list-style-type: none"> • 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 Summary Plan Description) • Other preventive items and services (See the Summary Plan Description for more information) 	<p>\$0 Copayment per visit; 100% Coverage</p>												
<p>OTHER PRIMARY CARE SERVICES:</p> <ul style="list-style-type: none"> • Medical Physician Services • Illness and Injury • Hearing Exams • X-Ray and Laboratory Procedures 	<p>\$0 Copayment per visit; 100% Coverage</p>												
<p>SPECIALTY CARE:</p> <ul style="list-style-type: none"> • Medical Physician Services • Illness and Injury • OB/GYN Services • X-Ray and Laboratory Procedures 	<p>\$0 Copayment per visit; 100% Coverage</p>												
<p>URGENT CARE CENTER SERVICES:</p> <ul style="list-style-type: none"> • Medical Physician Services • Illness and Injury 	<p>\$0 Copayment per visit; 100% Coverage</p>												
<p>TELEHEALTH SERVICES:</p>	<p>\$0 Copayment per consultation; 100% Coverage</p>												
<p>VISION CARE:</p> <ul style="list-style-type: none"> • One routine vision exam per Calendar Year • Other eye care office visits 	<p>\$0 Copayment per visit; 100% Coverage</p>												
<p>ALLERGY SERVICES:</p> <ul style="list-style-type: none"> • Physician Services • Testing & Treatment 	<p>\$0 Copayment per service; 100% Coverage</p>												
<p>DIAGNOSTIC SERVICES: (Including but not limited to CT Scan, MRI, PET/SPECT, ERCP)</p>	<p>\$0 Copayment per service; 100% Coverage</p>												
<p>OUTPATIENT SERVICES:</p> <ul style="list-style-type: none"> • Surgery and Other Outpatient Services 	<p>\$0 Copayment per service; 100% Coverage</p>												
<p>HOSPITAL INPATIENT SERVICES:</p> <ul style="list-style-type: none"> • Physician Services • Semi-Private Room 	<p>\$0 Copayment per service; 100% Coverage</p>												
<p>MATERNITY SERVICES:</p> <ul style="list-style-type: none"> • Physician Services (Prenatal, delivery, and postnatal care) • Maternity Hospitalization <p style="text-align: center;">Newborn care and other services covered only for enrolled child of employee or employee's spouse. Eligible child must be enrolled within 30 days of birth or adoption. No coverage for children of employee's dependent child.</p>	<p>\$0 Copayment per service; 100% Coverage</p>												
<p>EMERGENCY ROOM SERVICES: Must be Medically Necessary to be covered at 100%. Members can use participating urgent care facilities in urgent but non-emergency situations.</p>	<p>\$0 Copayment per service; 100% Coverage</p>												
<p>EMERGENCY AMBULANCE SERVICES: (Must be Medically Necessary)</p>	<p>80% Coverage</p>												
<p>DURABLE MEDICAL EQUIPMENT AND PROSTHETIC DEVICES: (Orthotic devices limited to two pairs every 12 months)</p>	<p>\$0 Copayment per service; 100% Coverage</p>												
<p>SKILLED NURSING FACILITY SERVICES: (Limited to 60 days per Calendar Year)</p>	<p>80% Coverage</p>												
<p>DIABETIC SUPPLIES: For Diabetic Supplies call VIVA HEALTH. Injectable and oral diabetic medications covered under prescription drug rider.</p>	<p>\$0 Copayment; 100% Coverage</p>												
<p>REHABILITATION SERVICES: Physical, Speech, and Occupational Therapy (Limited to 60 visits each per Calendar Year. Cardiac Rehabilitation is limited to 36 visits per episode.)</p>	<p>\$0 Copayment per visit/admission; 100% Coverage</p>												
<p>HOME HEALTH CARE SERVICES: (Limited to 60 visits per Calendar Year)</p>	<p>\$0 Copayment per visit; 100% Coverage</p>												
<p>HOSPICE SERVICES: (Limited to 180 days per lifetime)</p>	<p>\$0 Copayment per visit; 100% Coverage</p>												
<p>CHIROPRACTIC SERVICES: (Limited to 60 visits per Calendar Year)</p>	<p>\$0 Copayment per visit; 100% Coverage</p>												

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BENEFITS	COVERAGE
TEMPOROMANDIBULAR JOINT DISORDER (TMJ) PHASE I TREATMENT:	\$0 Copayment per service; 100% Coverage
SLEEP DISORDERS:	\$0 Copayment per visit/service; 100% Coverage
TRANSPLANT SERVICES:	\$0 copayment per service; 100% Coverage
MENTAL HEALTH & SUBSTANCE USE DISORDER SERVICES¹:	
<ul style="list-style-type: none"> • Inpatient Services (limited to 30 days for mental health and 30 days for substance use disorder per calendar year and a lifetime limit of 60 days each) • Outpatient Services² (limited to 60 combined mental health and substance use disorder outpatient visits per member each year) 	\$0 Copayment per visit/service; 100% Coverage

¹Certain diagnoses are excluded from coverage. Treatment at a residential facility is not a covered service. See your Summary Plan Description for details.
²Limited to treatment in an outpatient facility or free-standing substance use disorder facility only.

PHARMACY DEDUCTIBLE: Applies to all drugs except for oral contraceptives and other preventive drugs required by the Affordable Care Act. \$100 per individual; \$300 aggregate amount per family

COVERED PRESCRIPTION DRUGS: Some medications may require prior authorization from VIVA HEALTH and specialty medications may be restricted to purchase from Accredo pharmacy. For further information, please contact VIVA HEALTH Customer Service at (205) 558-7474 or 1-800-294-7780. When generic is available, Member pays the difference between the generic and Brand Name price, plus Copayment. Check with your participating pharmacy to learn if it is eligible to offer a 90-day supply at retail.

<p>PRESCRIPTION DRUG CARD:</p> <p>Non-Maintenance Prescriptions Up to a 30 day supply at retail.</p> <p>Maintenance Prescriptions up to a 90 day supply; one copay for <u>each</u> 30 day supply.</p> <p>Mail Order requires only two copays for a 90-day supply with no shipping fee. Additional information may be obtained at 1-800-698-3757 or www.Express-Scripts.com.</p> <p>Specialty Drugs 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.</p> <p>Benefits are not provided for fertility drugs.</p>	<p>EXPRESS SCRIPTS PARTICIPATING PHARMACY NETWORK:</p> <p>Each prescription purchased from a Participating Pharmacy will be covered at 100% after the deductible with the following copays:</p> <table border="1" style="width: 100%; border-collapse: collapse; margin-top: 10px;"> <thead> <tr> <th>Tier</th> <th>Type</th> <th>Copay per 30 day supply³</th> </tr> </thead> <tbody> <tr> <td>1</td> <td>Generic</td> <td style="text-align: center;">\$10</td> </tr> <tr> <td>2</td> <td>Preferred Brand Name</td> <td style="text-align: center;">\$50</td> </tr> <tr> <td>3</td> <td>Non-Preferred Brand Name</td> <td style="text-align: center;">\$75</td> </tr> <tr> <td>4</td> <td>Specialty</td> <td style="text-align: center;">50%</td> </tr> </tbody> </table> <p>³Out-Of-Pocket Maximum: The benefit increases to 100% of the Allowed Amount after the annual out-of-pocket maximum is met. The out-of-pocket limit is \$5,000 per individual not to exceed \$10,000 per family.</p> <p>Insulin, needles, and syringes purchased on the same day will have one copay; otherwise, each has a separate copay.</p> <p>Contraceptives are covered at 100% for all FDA approved contraceptives prescribed by a physician.</p>	Tier	Type	Copay per 30 day supply ³	1	Generic	\$10	2	Preferred Brand Name	\$50	3	Non-Preferred Brand Name	\$75	4	Specialty	50%	<p>NON-PARTICIPATING PHARMACY:</p> <p>Not covered. No benefits for prescriptions purchased at a non-Participating Pharmacy. A participating pharmacy is a pharmacy contracted with Express Scripts, Inc.</p> <p>SMOKING CESSATION PRODUCTS:</p> <p>100% coverage for up to 12 weeks without prior authorization per calendar year for generic Zyban, generic nicotine patch, gum, and lozenge, and nicotine inhaler or nasal spray. 100% coverage for up to 24 weeks without prior authorization per calendar year for varenicline tartrate (Chantix). Prior authorization must be obtained in order to access additional courses of treatment covered at 100%.</p>
Tier	Type	Copay per 30 day supply ³															
1	Generic	\$10															
2	Preferred Brand Name	\$50															
3	Non-Preferred Brand Name	\$75															
4	Specialty	50%															

ALLOWED AMOUNT OR ALLOWANCE: The "Allowed Amount" or "Allowance" for all Covered Services is determined by the Claims Administrator. The Claims Administrator relies upon in-network provider negotiated rates to determine the relative value for services. The Allowed Amount may not correspond to the usual or customary charge made by a physician, hospital, dentist or other medical provider or by other physicians and medical providers in any geographic area.

DENTAL BENEFITS, Administered by Southland Dental

The Dental Plan allows you to seek treatment from any licensed dentist. Please refer to the Southland Dental Member Handbook for covered benefits, limitations, and exclusions. The Dental Plan is included in the health plan premium for VIVA HEALTH and is administered by Southland Dental. There is no additional cost for this plan. For questions regarding the dental plan please contact **Southland Dental Customer Service at 1-800-476-3010**.

Type I Diagnostic/Preventive Services	
<ul style="list-style-type: none"> • Routine oral exams, Fluoride treatments (children under 19), Cleanings, X-Rays (limitations may apply), Sealants, Space Maintainers, and Prophylaxis 	100% coverage of Maximum Plan Allowance
Type II Basic Services	
<ul style="list-style-type: none"> • Fillings, Surgical Extractions, Palliative Services, General Anesthesia, and Endodontics (root canals) 	80% coverage of Maximum Plan Allowance
Type III Major Services	
<ul style="list-style-type: none"> • Major Restorative (crowns, bridges, and dentures), Denture Repair, and Periodontics 	50% coverage of Maximum Plan Allowance
Maximum Dental Benefit: \$1,000 Calendar Year limit. \$25 per person/\$75 per family per calendar year deductible applies to Basic and Major Services. Please refer to the dental schedule of benefits, limitations, and exclusions for full benefit descriptions. Time served on a prior carrier's dental plan with your current employer may be credited toward the Southland Dental plan's waiting periods	

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 state of Alabama or with the Subscriber (exceptions apply), and meet additional qualifying criteria. For exceptions and additional qualifying criteria, please refer to the Summary Plan Description.
- 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)。