IRON REHEALTH an Arsenal company

# GOLD

**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 DEDUCTIBLE:** Applies ONLY to those benefits with coinsurance coverage when the Member pays a set percentage of the cost or when "100% Coverage after deductible" is noted. Does not apply to benefits with a copayment. Does not apply to Biological, Biotechnical, and Specialty Pharmaceuticals. | $600 per individual;<br>$1,200 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. | $6,000 per individual;<br>$12,000 per family |
| **PREVENTIVE CARE:**<br>• Well Baby Care (Children under age 3)<br>• Routine Physicals (One per Calendar Year for ages 3+)<br>• Covered Immunizations<br>• OB/GYN Preventive Visit (One per Calendar Year)<br>• Preventive Prenatal Care (As defined in the Certificate of Coverage)<br>• Other preventive items and services. See Certificate of Coverage for more information | 100% Coverage |
| **OTHER PRIMARY CARE SERVICES:**<br>• Medical Physician Services<br>• Hearing Exams<br>• Illness and Injury | $35 Copayment per visit |
| **SPECIALTY CARE:** *(No PCP Referral Required)*<br>• Medical Physician Services<br>• OB/GYN Services<br>• Illness and Injury | $50 Copayment per visit |
| **URGENT CARE CENTER SERVICES:**<br>• Medical Physician Services<br>• Illness and Injury | $35 Copayment per visit |
| **TELEHEALTH SERVICES:** | $0 Copayment per consultation |
| **VISION CARE:** *(No PCP Referral Required)*<br>• Illness and Injury | $50 Copayment per visit |
| **ALLERGY SERVICES:** *(No PCP Referral Required)*<br>• Physician Services<br>• Testing and Treatment | $50 Copayment per visit<br>80% Coverage |
| **CHRONIC CARE MAINTENANCE:** *(Including, but not limited to, dialysis, IV therapy, chemotherapy, radiation therapy, wound care, wound therapy)* | 100% Coverage |
| **DIAGNOSTIC SERVICES:**<br>• Laboratory procedures (including covered genetic testing), X-Rays, and pathology (physician's office)<br>• Laboratory procedures (including covered genetic testing), X-Rays, and pathology (outpatient facility)<br>• Other Diagnostic Services (Including, but not limited to, CT Scan, MRI, PET/SPECT, ERCP) | 100% Coverage<br>$240 Copayment per visit<br>$250 Copayment per visit |
| **OUTPATIENT SERVICES:**<br>• Physician Surgery and Other Outpatient Services<br>• Facility Surgery and Other Outpatient Services<br>• Outpatient Hospital Observation (No procedure performed) | 100% Coverage after deductible<br>$240 Copayment per visit<br>$240 Copayment per day |
| **HOSPITAL INPATIENT SERVICES:**<br>• Physician Services<br>• Facility Services | 100% Coverage after deductible<br>$240 Copayment per day (Days 1-5) |
| **MATERNITY SERVICES:**<br>• Physician Prenatal and Postnatal Services<br>• Physician Delivery Services<br>• Maternity Hospitalization<br>**Newborn care and other services covered only 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.** | 100% Coverage after deductible<br>100% Coverage after deductible<br>$240 Copayment per day (Days 1-5) |
| **EMERGENCY ROOM SERVICES:** *(Cost sharing waived if admitted within 24 hours)*<br>• Physician Services<br>• Facility Services | $50 Copayment per visit<br>$250 Copayment per visit |
| **EMERGENCY AMBULANCE SERVICES:** *(Must be Medically Necessary)* | 80% Coverage |
| **DURABLE MEDICAL EQUIPMENT AND PROSTHETIC DEVICES:** | 80% Coverage |

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| MEDICAL BENEFITS | COVERAGE |
|---|---|
| **SKILLED NURSING FACILITY SERVICES:** *(100 days per Lifetime)* | 100% Coverage |
| **DIABETES SELF-MANAGEMENT EDUCATION:** | $50 Copayment per visit |
| **DIABETIC SUPPLIES:** Insulin covered under prescription drug rider. For Diabetic Supplies call VIVA HEALTH. | 80% Coverage |
| **REHABILITIATION SERVICES:** Physical, Speech, and Occupational Therapy *(Limited to 60 total inpatient days and 25 total outpatient visits per Calendar Year)* | 80% Coverage |
| **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 |
| **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 |
| **TEMPOROMANDIBULAR JOINT DISORDER:** | $50 Copayment per visit |
| **SLEEP DISORDERS:** | $50 Copayment per visit |
| • Sleep Study | 80% Coverage per sleep study |
| **TRANSPLANT SERVICES:** | |
| • Physician Services | 100% Coverage after deductible |
| • Semi-Private Room | $240 Copayment per day (Days 1-5) |
| **MENTAL HEALTH & SUBSTANCE ABUSE INPATIENT SERVICES[1]:** | |
| • Physician Services | 100% Coverage after deductible |
| • Semi-Private Room | $240 Copayment per day (Days 1-5) |
| **MENTAL HEALTH & SUBSTANCE ABUSE OUTPATIENT SERVICES[1]:** | |
| • Outpatient Services *(Including, but not limited to, Intensive Outpatient Services and Partial Hospitalization)* | $50 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 |
|---|---|
| **COVERED PRESCRIPTION DRUGS[2]:** | |
| • **Tier 1 (Preferred Generic Drugs)** | |
| ○ From a Participating Pharmacy | $10 Copayment per 31-day supply |
| ○ Mail-order | $25 Copayment per 90-day supply |
| ○ Participating Pharmacy | $30 Copayment per 90-day supply |
| • **Tier 2 (Generic Drugs)** | |
| ○ From a Participating Pharmacy | $20 Copayment per 31-day supply |
| ○ Mail-order | $50 Copayment per 90-day supply |
| ○ Participating Pharmacy | $60 Copayment per 90-day supply |
| • **Tier 3 (Preferred Brand and Non-Preferred Generic Drugs)** | |
| ○ From a Participating Pharmacy | $40 Copayment per 31-day supply |
| ○ Mail-order | $100 Copayment per 90-day supply |
| ○ Participating Pharmacy | $120 Copayment per 90-day supply |
| • **Tier 4 (Non-Preferred Brand and Non-Preferred Generic Drugs)** | |
| ○ From a Participating Pharmacy | $80 Copayment per 31-day supply |
| ○ Mail-order | $200 Copayment per 90-day supply |
| ○ Participating Pharmacy | $240 Copayment per 90-day supply |
| • **Tier 5 (Preferred Biological Drugs, Biotechnical Drugs, and Specialty Pharmaceuticals[3])** | $125 Copayment per 31-day supply |
| • **Tier 6 (Non-preferred Biological Drugs, Biotechnical Drugs, and Specialty Pharmaceuticals[3])** | $250 Copayment per 31-day supply |
| • **Select Generic Oral Contraceptives** | 100% Coverage[4] |
| • **Diabetic Testing Supplies (OneTouch glucose meters, OneTouch 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).

VIVA HEALTH®