THE HEALTH CARE AUTHORITY OF THE CITY OF ANNISTON

Effective Dates: January 1, 2023 – December 31, 2023

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	TIER 1 COVERAGE* RMC/Stringfellow Network	TIER 2 COVERAGE** UAB+ Network	TIER 3 COVERAGE*** VIVA HEALTH Network
CALENDAR YEAR OVERALL DEDUCTIBLE: Applies ONLY to those benefits with coinsurance coverage when the Member pays a set percentage of the cost and it is not otherwise noted that the benefit coinsurance is exempted from the deductible or when "100% Coverage, subject to the deductible" is noted. Does not apply to benefits with a copayment. Does not apply to Biological, Biotechnical, and Specialty Pharmaceuticals ordered through the pharmacy benefit but will apply to such drugs when provided directly by a physician or hospital. See separate pharmacy deductibles on next page. Deductible amounts paid on any tier apply toward all tiers, but Tier 3 has a higher deductible requirement.	$500 per individual; $1,500 per family, not to exceed $500 per any individual		$3,000 per individual; $6,000 per family, not to exceed $3,000 per any individual
PER ADMISSION INPATIENT HOSPITAL DEDUCTIBLE: Applies ONLY to each inpatient hospital admission in a Tier 2 or Tier 3 hospital. Inpatient hospital deductible counts toward the Calendar Year Overall Deductible but will be charged at each Tier 2 and Tier 3 inpatient hospital admission until the applicable Calendar Year Out-of-Pocket Maximum is met.	No Charge	$500 per admission	$3,000 per admission
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. Out-of-pocket cost sharing paid on any tier applies toward all tiers, but Tier 3 has a higher out-of-pocket maximum.	$5,000 per individual; $10,000 per family, not to exceed $5,000 per any individual		$6,000 per individual; $12,000 per family, not to exceed $6,000 per any individual
PREVENTIVE CARE: • **Well Baby Care** (Children under age 3) • **Routine Physicals** (One per Calendar Year for ages 3+) • **Covered Immunizations** • **Preventive Prenatal Care** • **OB/GYN Preventive Visit** (One per Calendar Year) • **Other preventive items and services** (See Certificate of Coverage for recommendations and guidelines)	100% Coverage	100% Coverage	100% Coverage
OTHER PRIMARY CARE SERVICES: • **Medical Physician Services** • **Illness and Injury** • **Hearing Exams**	$30 Copayment per visit	$30 Copayment per visit	$30 Copayment per visit
SPECIALTY CARE: *(No PCP Referral Required)* • **Medical Physician Services** • **Illness and Injury** • **OB/GYN Services**	$45 Copayment per visit	$45 Copayment per visit	$45 Copayment per visit
URGENT CARE CENTER SERVICES: • **Medical Physician Services** • **Illness and Injury**	$45 Copayment per visit	$45 Copayment per visit	$45 Copayment per visit
TELADOC TELEHEALTH SERVICES:	$10 per consultation		
EMERGENCY ROOM SERVICES: *(Cost sharing waived if admitted within 24 hours)* • **Facility Services** • **Physician Services**	$150 Copayment per visit $50 Copayment per visit	$150 Copayment per visit $50 Copayment per visit	$150 Copayment per visit $50 Copayment per visit
EMERGENCY AMBULANCE SERVICES: *(Must be Medically Necessary)*	80% Coverage		
HOSPITAL INPATIENT SERVICES: • **Facility Services** • **Physician Services**	100% Coverage 90% Coverage	90% Coverage *plus* $500 per admission hospital deductible 90% Coverage	70% Coverage *plus* $3,000 per admission hospital deductible 70% Coverage
SECOND SURGICAL OPINION:	90% Coverage (deductible *does not* apply)	90% Coverage (deductible *does not* apply)	70% Coverage (deductible *does not* apply)

RMC HEALTH SYSTEM

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OUTPATIENT SERVICES:			
• **Facility Services**	$100 Copayment[1]	90% Coverage	70% Coverage
• **Physician Services**	90% Coverage	90% Coverage	70% Coverage
MATERNITY SERVICES[2]:			
• **Physician Prenatal and Postnatal Services**	$45 Copayment per delivery	$45 Copayment per delivery	$45 Copayment per delivery
• **Physician Delivery Services**	90% Coverage	90% Coverage	70% Coverage
• **Maternity Hospitalization**	100% Coverage	90% Coverage *plus* $500 per admission hospital deductible	70% Coverage *plus* $3,000 per admission hospital deductible
DIAGNOSTIC SERVICES:			
• **X-Rays, laboratory procedures and other diagnostic services** *(Including, but not limited to, covered genetic testing, CT Scan, MRI, PET/SPECT, ERCP)*	100% Coverage	90% Coverage	70% Coverage
• **Physician interpretation fees for diagnostic services**	90% Coverage (deductible *does not* apply)	90% Coverage (deductible *does not* apply)	
• **Other Physician services**	90% Coverage	90% Coverage	
CHRONIC CARE MAINTENANCE: *(Inpatient and outpatient only. Not covered in physician's office.)*			
• **Chemotherapy, radiation therapy, wound care, and wound therapy**	100% Coverage	90% Coverage	70% Coverage
• **IV therapy**	100% Coverage	Not Covered	Not Covered
• **Physician fees for chronic care maintenance**	90% Coverage (deductible *does not* apply)	90% Coverage (deductible *does not* apply)	70% Coverage
DIALYSIS:			
• **Outpatient Dialysis**	90% Coverage	90% Coverage	90% Coverage
• **Physician Fees**	100% Coverage (subject to the deductible)	100% Coverage (subject to the deductible)	70% Coverage
VISION CARE: *(No PCP Referral Required)*			
• **Illness and Injury**	$45 Copayment per visit	$45 Copayment per visit	$45 Copayment per visit
ALLERGY SERVICES: *(No PCP Referral Required)*			
• **Physician Services**	$45 Copayment	$45 Copayment	$45 Copayment
• **Testing and Treatment**	80% Coverage	80% Coverage	80% Coverage
DURABLE MEDICAL EQUIPMENT AND PROSTHETIC DEVICES:	80% Coverage		
SKILLED NURSING FACILITY SERVICES: *(Limited to 100 days per Lifetime)*	Not Available	90% Coverage	70% Coverage
DIABETES SELF-MANAGEMENT EDUCATION:	$45 Copayment per visit	$45 Copayment per visit	$45 Copayment per visit
DIABETIC SUPPLIES:	Not covered under the medical benefit. See pharmacy benefit for coverage.		
REHABILITIATION SERVICES: Physical, Speech, and Occupational Therapy *(Limited to 60 total inpatient days and 30 total outpatient visits per Calendar Year)*	90% Coverage (deductible *does not* apply)	90% Coverage (deductible *does not* apply)	70% Coverage (deductible *does not* apply)
HABILITATION SERVICES: Physical, Speech, and Occupational Therapy and Applied Behavior Analysis *(limited to a diagnosis of Autism, Autism Spectrum Disorder, or Pervasive Developmental Delay)*	90% Coverage (deductible *does not* apply)	90% Coverage (deductible *does not* apply)	70% Coverage (deductible *does not* apply)
CHIROPRACTIC SERVICES: *(No PCP Referral Required. Limited to 25 visits per Calendar Year.)*			
• Physician Services	$45 Copayment	$45 Copayment	$45 Copayment
• Testing and Treatment	80% Coverage	80% Coverage	80% Coverage
HOME HEALTH CARE SERVICES: *(Limited to 60 visits per Calendar Year)*	80% Coverage		
TEMPOROMANDIBULAR JOINT DISORDER:	$45 Copayment per visit	$45 Copayment per visit	$45 Copayment per visit
SLEEP DISORDERS:	$45 Copayment per visit;	$45 Copayment per visit;	$45 Copayment per visit;
• **Sleep Study**	90% Coverage per sleep study	90% Coverage per sleep study	70% Coverage per sleep study
TRANSPLANT SERVICES:			
• **Facility Services**	Not Available	90% Coverage *plus* $500 per admission hospital deductible	70% Coverage *plus* $3,000 per admission hospital deductible
• **Physician Services**		90% Coverage	70% Coverage

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MENTAL HEALTH & SUBSTANCE ABUSE INPATIENT SERVICES[3]:			
• **Inpatient Facility Services**	100% Coverage	90% Coverage *plus* $500 per admission hospital deductible	70% Coverage *plus* $3,000 per admission hospital deductible
• **Inpatient Physician Services**	90% Coverage	90% Coverage	70% Coverage
MENTAL HEALTH & SUBSTANCE ABUSE OUTPATIENT SERVICES[3]:			
• **Outpatient Services**	$45 Copayment per visit	$45 Copayment per visit	$45 Copayment per visit
• **Intensive Outpatient Services and Partial Hospitalization**	100% Coverage	100% Coverage	100% Coverage

NOTES

[1]Outpatient facility services received at The Surgery Center in Oxford, AL (TSC) are subject to 10% coinsurance (deductible does not apply) in addition to the $100 copayment.
[2]Eligible baby must be enrolled in plan within 30 days of birth or adoption for baby's care to be covered.
[3]Treatment at a residential facility is not a covered service. Certain diagnoses are excluded from coverage. See your Certificate of Coverage for details.

NETWORK

*"RMC" means Regional Medical Center Anniston, Stringfellow Memorial Hospital, and all RMC satellite clinics.

**The UAB+ network (Tier 2) includes University Hospital, UAB Women and Infants Center, UAB Highlands, The Kirklin Clinic, Medical West, UAB Callahan Eye Hospital, Spain Rehabilitation Center, all UAB satellite clinics, and Children's of Alabama.

***The VIVA HEALTH network (Tier 3) includes hospitals and health centers contracted with VIVA HEALTH but outside of RMC and UAB.

PHARMACEUTICAL BENEFITS, *Administered by Proxys/MedOne*	TIER 1 COVERAGE The Pharmacy at RMC	TIER 2 COVERAGE Select Local Pharmacies	TIER 3 COVERAGE All Other Pharmacies
Pharmaceutical Deductible	$100 Brand Name Deductible	$200 Brand Name Deductible	$300 Brand Name Deductible
• **Generic Drugs**	$8 (30 day supply) $16 (90 day supply)	$20 (30 day supply) $40 (90 day supply)	$25 (30 day supply) $50 (90 day supply)
• **Preferred Brand Name Drugs**	$25 (30 day supply) $50 (90 day supply)	$45 (30 day supply) $90 (90 day supply)	$55 (30 day supply) $110 (90 day supply)
• **Non-Preferred Brand Name Drugs**	$45 (30 day supply) $90 (90 day supply)	$70 (30 day supply) $140 (90 day supply)	$80 (30 day supply) $160 (90 day supply)
• **Specialty Drugs**	70% Coverage (30 day supply only)	70% Coverage (30 day supply only)	70% Coverage (30 day supply only)
• **Mail Order**	Mail order not covered	Mail order not covered	Mail order not covered

VIVA HEALTH Customer Service: (205) 558-7474 or 1-800-294-7780 | Visit our Website at www.vivahealth.com/rmc

Eligible Dependent: Eligible Employee's lawful eligible spouse, children of Eligible Employees up to age 26, and disabled dependents who meet eligibility criteria.
Working Spouse Rule: Working spouses are NOT eligible for coverage under the this plan if health care coverage is available through his or her employer's plan and he/she is eligible to enroll for such coverage.
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).