

Effective Dates: January 1, 2025 – December 31, 2025

Attachment A to Certificate of Coverage

The Plan's services and benefits, with their copayments, coinsurances, 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. As a member of VIVA HEALTH through Medical West, you have a customized provider network that includes the physicians and facilities associated with Medical West and UAB. UAB means UAB Hospital, UAB Women and Infants Center, UAB Highlands, The Kirklin Clinic of UAB Hospital, UAB Callahan Eye Hospital, UAB Spain Rehabilitation Center, and all UAB and Medical West satellite clinics. You have access to VIVA HEALTH's entire network of OB/GYN, vision, pain management, podiatry, dermatology, allergy/immunology, mental health, and chiropractic providers. Medical West members under the age of 18 have access to VIVA HEALTH's entire pediatric network.

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. Does not apply to benefits with a copayment. Does not apply to Biological, Biotechnical and Specialty Pharmaceuticals ordered through Express Scripts but will apply to such drugs when provided directly by a physician or hospital. Amounts from manufacturer coupons or similar assistance programs used to satisfy Member Coinsurance do not count toward the Deductible.	\$400 per individual; \$800 per family
CALENDAR YEAR OUT-OF-POCKET MAXIMUM: The most a Member will pay per Calendar Year for qualified medical, mental, and substance use disorder 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. See the Certificate of Coverage for details. Amounts from manufacturer coupons or similar assistance programs used to satisfy Member Copayments or Coinsurance do not count toward the Out-of-Pocket Maximum.	\$7,900 per individual; \$15,800 per family
PREVENTIVE CARE: <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 • Nutritionist Preventive Visits (Up to 3 per Calendar Year with a Registered Dietitian or Nutritionist) • Other preventive items and services. See Certificate of Coverage for more information 	100% Coverage
OTHER PRIMARY CARE SERVICES: <ul style="list-style-type: none"> • Medical Physician Services • Hearing Exams • Illness and Injury 	\$35 Copayment per visit
SPECIALTY CARE: (No PCP Referral Required) <ul style="list-style-type: none"> • Medical Physician Services • OB/GYN Services • Illness and Injury 	\$50 Copayment per visit
URGENT CARE CENTER SERVICES: <ul style="list-style-type: none"> • Medical Physician Services • Illness and Injury 	\$50 Copayment per visit
VISION CARE: (No PCP Referral Required) <ul style="list-style-type: none"> • One routine vision exam per Calendar Year • Other eye care office visits 	\$50 Copayment per visit
ALLERGY SERVICES: (No PCP Referral Required) <ul style="list-style-type: none"> • Physician Services • Testing and Treatment 	\$50 Copayment per visit 90% Coverage
CHRONIC CARE MAINTENANCE: (Including, but not limited to, dialysis, radiation therapy, wound care, wound therapy)	90% Coverage
LABORATORY SERVICES: <ul style="list-style-type: none"> • Laboratory Procedures • Covered Genetic Testing 	90% Coverage 80% Coverage
DIAGNOSTIC SERVICES: <ul style="list-style-type: none"> • X-Rays • Other Diagnostic Services (Including, but not limited to, CT Scan, MRI, PET/SPECT, ERCP) 	\$10 Copayment per image 90% Coverage
OUTPATIENT SERVICES: <ul style="list-style-type: none"> • Surgery and Other Outpatient Services 	90% Coverage
HOSPITAL INPATIENT SERVICES: <ul style="list-style-type: none"> • Physician and Facility Services 	90% Coverage
MATERNITY SERVICES: (Covered for employee and employee's spouse; not covered for dependent children except as provided under Preventive Care) <ul style="list-style-type: none"> • Physician Services (Prenatal, delivery, and postnatal care) • Maternity Hospitalization 	\$50 Copayment per delivery 90% Coverage
Eligible baby must be enrolled in plan within 30 days of birth or adoption for care to be covered.	
EMERGENCY ROOM SERVICES:	\$275 Copayment per visit
EMERGENCY AMBULANCE SERVICES: (Must be Medically Necessary)	90% Coverage
DURABLE MEDICAL EQUIPMENT AND PROSTHETIC DEVICES:	90% Coverage
SKILLED NURSING FACILITY SERVICES: (100 days per Lifetime)	90% Coverage
MEDICAL NUTRITION SERVICES: (Limited to 6 visits per Calendar Year with a Registered Dietitian or Nutritionist)	\$50 Copayment per visit
DIABETES SELF-MANAGEMENT EDUCATION	\$50 Copayment per visit

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MEDICAL BENEFITS	COVERAGE
DIABETIC SUPPLIES: Insulin covered under prescription drug rider. For Diabetic Supplies call VIVA HEALTH.	100% Coverage
REHABILITATION AND HABILITATION SERVICES: Physical, Speech, and Occupational Therapy and Applied Behavior Analysis (Limited to 60 total inpatient days & 30 total outpatient visits per Calendar Year for medical diagnoses)	90% Coverage
HOME HEALTH CARE SERVICES: (Limited to 60 visits per Calendar Year)	90% Coverage
CHIROPRACTIC SERVICES: (No PCP Referral Required. Covered up to 25 visits per Calendar Year)	\$50 Copayment per visit
TEMPOROMANDIBULAR JOINT DISORDER:	\$50 Copayment per visit
SLEEP DISORDERS:	\$50 Copayment per visit;
• Sleep Study	90% Coverage per sleep study
TRANSPLANT SERVICES:	90% Coverage
MENTAL HEALTH & SUBSTANCE USE DISORDER SERVICES:	90% Coverage
• Inpatient	\$50 Copayment per visit
• Outpatient	

PHARMACEUTICAL BENEFITS	COVERAGE
PHARMACY DEDUCTIBLE: Applies to all drugs except for insulin, generic oral contraceptives, and other preventive drugs required by the Affordable Care Act.	\$150 per individual; \$300 aggregate amount per family

COVERED PRESCRIPTION DRUGS¹:

- **Tier 1 (Preferred Generic Drugs)**
 - Participating Pharmacy \$5 Copayment per 30-day supply
 - Mail-order \$12 Copayment per 90-day supply²
 - Participating Pharmacy \$15 Copayment per 90-day supply²
- **Tier 2 (Non-Preferred Generic Drugs)**
 - Participating Pharmacy \$20 Copayment per 30-day supply
 - Mail-order \$50 Copayment per 90-day supply²
 - Participating Pharmacy \$60 Copayment per 90-day supply²
- **Tier 3 (Preferred Brand and Non-Preferred Generic Drugs)**
 - Participating Pharmacy \$60 Copayment per 30-day supply
 - Mail-order \$150 Copayment per 90-day supply²
 - Participating Pharmacy \$180 Copayment per 90-day supply²
- **Tier 4 (Non-Preferred Brand and Non-Preferred Generic Drugs)**
 - Participating Pharmacy \$80 Copayment per 30-day supply
 - Mail-order \$200 Copayment per 90-day supply²
 - Participating Pharmacy \$240 Copayment per 90-day supply²
- **Tier 5 (Biological Drugs, Biotechnical Drugs, and Specialty Pharmaceuticals³ and Non-Preferred Drugs)** 70% Coverage
- **Oral Contraceptives** \$0 Copayment for generics and select brand drugs; Applicable Copayment for other 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

¹Some medications may require prior authorization from VIVA HEALTH. For further information, please contact Customer Service at the phone number listed below. ²A 90-day supply is as written by the provider, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. ³May 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 <https://www.vivahealth.com/Group/Login/>.

When generic is available, Member pays difference between generic and Brand price, plus Copayment.

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.
Working Spouse Rule:	Your spouse is NOT eligible for coverage under this plan if: <ul style="list-style-type: none"> 1. your spouse is eligible for coverage under his/her employer's plan AND 2. your spouse's employer pays at least 50% of total premium for individuals on any plan offered. Verification of the spouse's ineligibility for an employer plan that meets the provisions above is required for this plan to be primary. Your spouse may be eligible for secondary coverage under this plan if proof of other primary insurance is provided.
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 (including sex characteristics, including interstitial intersex traits; pregnancy or related conditions; sexual orientation; gender identity; and sex stereotypes). VIVA HEALTH does not exclude people or treat them differently because 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)。