

Effective Dates: January 1, 2024 – December 31, 2024

## 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
<b>CALENDAR YEAR DEDUCTIBLE:</b> 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.	\$275 per individual; \$550 per family
<b>CALENDAR YEAR OUT-OF-POCKET MAXIMUM:</b> 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.	\$7,900 per individual; \$15,800 per family
<b>PREVENTIVE CARE:</b> <ul style="list-style-type: none"> <li>Well Baby Care (Children under age 3)</li> <li>Routine Physicals (One per Calendar Year for ages 3+)</li> <li>Covered Immunizations</li> <li>OB/GYN Preventive Visit (One per Calendar Year)</li> <li>Preventive Prenatal Care</li> <li>Nutritionist Preventive Visits (Up to 3 per Calendar Year with a Registered Dietitian or Nutritionist)</li> <li>Other preventive items and services. See Certificate of Coverage for more information</li> </ul>	100% Coverage
<b>OTHER PRIMARY CARE SERVICES:</b> <ul style="list-style-type: none"> <li>Medical Physician Services</li> <li>Hearing Exams</li> <li>Illness and Injury</li> </ul>	\$35 Copayment per visit
<b>SPECIALTY CARE:</b> <i>(No PCP Referral Required)</i> <ul style="list-style-type: none"> <li>Medical Physician Services</li> <li>OB/GYN Services</li> <li>Illness and Injury</li> </ul>	\$50 Copayment per visit
<b>URGENT CARE CENTER SERVICES:</b> <ul style="list-style-type: none"> <li>Medical Physician Services</li> <li>Illness and Injury</li> </ul>	\$50 Copayment per visit
<b>VISION CARE:</b> <i>(No PCP Referral Required)</i> <ul style="list-style-type: none"> <li>One routine vision exam per Calendar Year</li> <li>Other eye care office visits</li> </ul>	\$50 Copayment per visit
<b>ALLERGY SERVICES:</b> <i>(No PCP Referral Required)</i> <ul style="list-style-type: none"> <li>Physician Services</li> <li>Testing and Treatment</li> </ul>	\$50 Copayment per visit 90% Coverage
<b>CHRONIC CARE MAINTENANCE:</b> <i>(Including, but not limited to, dialysis, radiation therapy, wound care, wound therapy)</i>	90% Coverage
<b>LABORATORY SERVICES:</b> <ul style="list-style-type: none"> <li>Laboratory Procedures</li> <li>Covered Genetic Testing</li> </ul>	90% Coverage 80% Coverage
<b>DIAGNOSTIC SERVICES:</b> <ul style="list-style-type: none"> <li>X-Rays</li> <li>Other Diagnostic Services <i>(Including, but not limited to, CT Scan, MRI, PET/SPECT, ERCP)</i></li> </ul>	\$10 Copayment per image 90% Coverage
<b>OUTPATIENT SERVICES:</b> <ul style="list-style-type: none"> <li>Surgery and Other Outpatient Services</li> </ul>	90% Coverage
<b>HOSPITAL INPATIENT SERVICES:</b> <ul style="list-style-type: none"> <li>Physician and Facility Services</li> </ul>	90% Coverage
<b>MATERNITY SERVICES:</b> <i>(Covered for employee and employee's spouse; not covered for dependent children except as provided under Preventive Care)</i> <ul style="list-style-type: none"> <li>Physician Services <i>(Prenatal, delivery, and postnatal care)</i></li> <li>Maternity Hospitalization</li> </ul>	\$50 Copayment per delivery 90% Coverage
<b>Eligible baby must be enrolled in plan within 30 days of birth or adoption for care to be covered.</b>	
<b>EMERGENCY ROOM SERVICES:</b>	\$275 Copayment per visit
<b>EMERGENCY AMBULANCE SERVICES:</b> <i>(Must be Medically Necessary)</i>	90% Coverage
<b>DURABLE MEDICAL EQUIPMENT AND PROSTHETIC DEVICES:</b>	90% Coverage
<b>SKILLED NURSING FACILITY SERVICES:</b> <i>(100 days per Lifetime)</i>	90% Coverage
<b>DIABETES SELF-MANAGEMENT EDUCATION</b>	\$50 Copayment per visit
<b>MEDICAL NUTRITION SERVICES:</b> <i>(Limited to 6 visits per Calendar Year with a Registered Dietitian or Nutritionist)</i>	\$50 Copayment per visit
<b>DIABETIC SUPPLIES:</b> Insulin covered under prescription drug rider. For Diabetic Supplies call VIVA HEALTH.	100% Coverage

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MEDICAL BENEFITS	COVERAGE
<b>REHABILITATION AND HABILITATION SERVICES:</b> 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
<b>HOME HEALTH CARE SERVICES:</b> (Limited to 60 visits per Calendar Year)	90% Coverage
<b>CHIROPRACTIC SERVICES:</b> (No PCP Referral Required. Covered up to 25 visits per Calendar Year)	\$50 copayment per visit
<b>TEMPOROMANDIBULAR JOINT DISORDER:</b>	\$50 Copayment per visit
<b>SLEEP DISORDERS:</b>	\$50 Copayment per visit;
• Sleep Study	90% Coverage per sleep study
<b>TRANSPLANT SERVICES:</b>	90% Coverage
<b>MENTAL HEALTH &amp; SUBSTANCE USE DISORDER SERVICES:</b>	90% Coverage
• Inpatient	\$50 Copayment per visit
• Outpatient	

PHARMACEUTICAL BENEFITS	COVERAGE
<b>COVERED PRESCRIPTION DRUGS<sup>1</sup>:</b>	
• <b>Tier 1 (Preferred Generic Drugs)</b>	
o Participating Pharmacy	\$5 Copayment per 30-day supply
o Mail-order	\$12 Copayment per 90-day supply
o Participating Pharmacy	\$15 Copayment per 90-day supply
• <b>Tier 2 (Non-Preferred Generic Drugs)</b>	
o Participating Pharmacy	\$20 Copayment per 30-day supply
o Mail-order	\$43 Copayment per 90-day supply
o Participating Pharmacy	\$60 Copayment per 90-day supply
• <b>Tier 3 (Preferred Brand and Non-Preferred Generic Drugs)</b>	
o Participating Pharmacy	\$40 Copayment per 30-day supply
o Mail-order	\$86 Copayment per 90-day supply
o Participating Pharmacy	\$120 Copayment per 90-day supply
• <b>Tier 4 (Non-Preferred Brand and Non-Preferred Generic Drugs)</b>	
o Participating Pharmacy	\$65 Copayment per 30-day supply
o Mail-order	\$162 Copayment per 90-day supply
o Participating Pharmacy	\$195 Copayment per 90-day supply
• <b>Tier 5 (Biological Drugs, Biotechnical Drugs, and Specialty Pharmaceuticals<sup>2</sup> and Non-Preferred Drugs)</b>	70% Coverage
• <b>Oral Contraceptives</b>	\$0 Copayment for generics and select brand drugs; Applicable Copayment for other brand drugs
• <b>Diabetic Testing Supplies [OneTouch and Freestyle (excluding Libre) glucose meters, OneTouch and Freestyle glucose test strips, and any brand of lancets/lancet devices]</b>	100% Coverage

<sup>1</sup>Some medications may require prior authorization from VIVA HEALTH. For further information, please contact Customer Service at the phone number listed below. <sup>2</sup>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 <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](http://www.vivahealth.com)**

<b>Pre-Existing Condition Policy:</b>	No pre-existing condition exclusions or waiting period.
<b>Eligible Dependent:</b>	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.
<b>Working Spouse Rule:</b>	Your spouse is NOT eligible for coverage under this plan if: <ol style="list-style-type: none"> <li>your spouse is eligible for coverage under his/her employer's plan AND</li> <li>your spouse's employer pays at least 50% of total premium for individuals on any plan offered.</li> </ol> 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.
<b>Nondiscrimination Notice:</b>	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.
<b>Language Assistance Services:</b>	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)。