VIVA HEALTH

VIVA VALUE 8000

Effective Dates: Coverage Beginning On or After January 1, 2024

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 medical and pharmaceutical benefits with coinsurance coverage when the Member pays a set percentage of the cost and when "after deductible" is noted. Does not apply to benefits with a copayment.	$8,000 per individual; $16,000 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.	$8,000 per individual; $16,000 per family
PREVENTIVE CARE: • 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: • Medical Physician Services • Hearing Exams • Illness and Injury • X-Rays and Laboratory Procedures ○ Covered Genetic Testing	$35 Copayment per visit 100% Coverage after Deductible
SPECIALTY CARE: *(No PCP Referral Required)* • Medical Physician Services • OB/GYN Services • Illness and Injury • X-Rays and Laboratory Procedures ○ Covered Genetic Testing	$50 Copayment per visit 100% Coverage after Deductible
URGENT CARE CENTER SERVICES: • Medical Physician Services • Illness and Injury	$50 Copayment per visit
TELADOC TELEHEALTH SERVICES: • Primary/Urgent Care Consultations • Behavioral Health Consultations	$55 per consultation $50 per consultation
VISION CARE: (*No PCP Referral Required)* • One routine vision exam per Calendar Year • Other eye care office visits	$50 Copayment per visit
ALLERGY SERVICES: *(No PCP Referral Required)* • Physician Services • Testing and Treatment	$50 Copayment per visit 100% Coverage after Deductible
CHRONIC CARE MAINTENANCE: *(Including but not limited to dialysis, radiation therapy, wound care, wound therapy)*	100% Coverage after Deductible
DIAGNOSTIC SERVICES: *(Including but not limited to X-Ray, CT Scan, MRI, PET/SPECT, ERCP)*	100% Coverage after Deductible
OUTPATIENT SERVICES: • Surgery and Other Outpatient Services	100% Coverage after Deductible
HOSPITAL INPATIENT SERVICES: • Physician and Facility Services	100% Coverage after Deductible
MATERNITY SERVICES: • Physician Services *(Prenatal, delivery, and postnatal care)* • Maternity Hospitalization **Newborn care and other services covered <u>only</u> 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.**	$50 Copayment per delivery 100% Coverage after Deductible
EMERGENCY ROOM SERVICES:	$500 Copayment per visit
EMERGENCY AMBULANCE SERVICES: *(Must be Medically Necessary)*	100% Coverage after Deductible
DURABLE MEDICAL EQUIPMENT AND PROSTHETIC DEVICES:	100% Coverage after Deductible
SKILLED NURSING FACILITY SERVICES: *(100 days per Lifetime)*	100% Coverage after Deductible
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
DIABETIC SUPPLIES: Insulin covered under prescription drug rider. For Diabetic Supplies call VIVA HEALTH.	100% Coverage after Deductible
HOME HEALTH CARE SERVICES:	100% Coverage after Deductible
CHIROPRACTIC SERVICES: *(No PCP Referral Required; Covered up to 25 visits per Calendar Year)*	$50 Copayment per visit

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MEDICAL BENEFITS	COVERAGE
REHABILITIATION AND HABILITATION SERVICES: Physical, Speech, and Occupational Therapy and Applied Behavior Analysis *(Limited to 60 total inpatient days and 30 total outpatient visits per Calendar Year for medical diagnoses)*	100% Coverage after Deductible
TEMPOROMANDIBULAR JOINT DISORDER:	$50 Copayment per visit
SLEEP DISORDERS:	$50 Copayment per visit
• Sleep Study	100% Coverage after Deductible
TRANSPLANT SERVICES:	100% Coverage after Deductible
MENTAL HEALTH & SUBSTANCE USE DISORDER SERVICES:	
• Inpatient Services	100% Coverage after Deductible
• Outpatient Services	$50 Copayment per visit

PHARMACEUTICAL BENEFITS	COVERAGE
PHARMACY DEDUCTIBLE: Applies to all Tier 5 drugs. When deductible applies, deductible must be satisfied before cost-sharing applies unless the overall Calendar Year Out-of-Pocket Maximum has been met.	Calendar year deductible applies to pharmacy benefits with a coinsurance. Does not apply to drugs with a copayment.
COVERED PRESCRIPTION DRUGS[1]:	
• **Tier 1 (Preferred Generic Drugs)**	
○ From a Participating Pharmacy	$10 Copayment per 30-day supply
○ Mail-order	$24 Copayment per 90-day supply
○ Participating Pharmacy	$30 Copayment per 90-day supply
• **Tier 2 (Non-Preferred Generic Drugs)**	
○ From a Participating Pharmacy	$30 Copayment per 30-day supply
○ Mail-order	$65 Copayment per 90-day supply
○ Participating Pharmacy	$90 Copayment per 90-day supply
• **Tier 3 (Preferred Brand and Non-Preferred Generic Drugs)**	
○ From a Participating Pharmacy	$60 Copayment per 30-day supply
○ Mail-order	$150 Copayment per 90-day supply
○ Participating Pharmacy	$180 Copayment per 90-day supply
• **Tier 4 (Non-Preferred Brand and Non-Preferred Generic Drugs)**	
○ From a Participating Pharmacy	$80 Copayment per 30-day supply
○ Mail-order	$200 Copayment per 90-day supply
○ Participating Pharmacy	$240 Copayment per 90-day supply
• **Tier 5 (Biological Drugs, Biotechnical Drugs, and Specialty Pharmaceuticals[2] and Non-Preferred Drugs)**	100% Coverage after Deductible
• **Oral Contraceptives**	$0 Copayment for generic 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 (deductible does not apply)

[1]Some medications may require prior authorization from VIVA HEALTH. For further information, please contact Customer Service at the phone number listed below.
[2]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.vivahealth.com/Group/plans/MN8K.

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).