



# VIVA PLATINUM WELLNESS

Effective Dates: Coverage Beginning On or After January 1, 2025  
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
<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. 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. Amounts from manufacturer coupons or similar assistance programs used to satisfy Member Copayments or Coinsurance do not count toward the Out-of-Pocket Maximum.	\$4,100 per individual; \$8,200 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>Preventive Prenatal Care</li> <li>OB/GYN Preventive Visit (One per Calendar Year)</li> <li>Nutritionist Preventive Visit (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>	\$25 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>	\$40 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>	\$40 Copayment per visit
<b>TELADOC TELEHEALTH SERVICES:</b> <ul style="list-style-type: none"> <li>Primary/Urgent Care Consultations</li> <li>Behavioral Health Consultations</li> </ul>	\$55 per consultation \$40 per consultation
<b>PEDIATRIC VISION CARE:</b> <i>(Covered for children ages 0 until age 19; No PCP Referral Required)</i> <ul style="list-style-type: none"> <li>One routine vision exam per plan year for children ages 0 until age 19</li> <li>Contacts or one pair of eyeglasses per plan year for children ages 0 until age 19</li> </ul> <p>These benefits are administered by VSP. Children must use VSP Advantage providers for routine eye exam and eyewear. Covered eyewear selected by VSP. Find VSP providers at <a href="http://www.vsp.com/advantage">www.vsp.com/advantage</a> or call 1-855-868-4561. See Attachment C for more information.</p>	100% Coverage
<b>PEDIATRIC DENTAL CARE:</b> <i>(Covered for children ages 0 until age 19)</i> For more information, go to <a href="http://www.deltadentalins.com/vivaehb">www.deltadentalins.com/vivaehb</a> or call 1-800-471-8148	Pediatric dental benefits provided by <b>Delta Dental PPO.</b>
<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>	\$40 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 \$200 Copayment per service
<b>OUTPATIENT SERVICES:</b> <ul style="list-style-type: none"> <li>Surgery and Other Outpatient Services</li> </ul>	\$200 Copayment per visit
<b>HOSPITAL INPATIENT SERVICES:</b> <ul style="list-style-type: none"> <li>Physician and Facility Services</li> </ul>	\$200 Copayment per day (Days 1-5)
<b>MATERNITY SERVICES:</b> <ul style="list-style-type: none"> <li>Physician Services <i>(Prenatal, delivery, and postnatal care)</i></li> <li>Maternity Hospitalization</li> </ul>	\$40 Copayment per delivery \$200 Copayment per day (Days 1-5)
<b>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.</b>	
<b>EMERGENCY ROOM SERVICES:</b>	\$200 Copayment per visit

MEDICAL BENEFITS	COVERAGE
<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>MEDICAL NUTRITION SERVICES:</b> <i>(Limited to 6 visits per Calendar Year with a Registered Dietitian or Nutritionist)</i>	\$40 Copayment per visit
<b>DIABETES SELF-MANAGEMENT EDUCATION:</b>	\$40 Copayment per visit
<b>DIABETIC SUPPLIES:</b> Insulin covered under prescription drug rider. For Diabetic Supplies call VIVA HEALTH.	90% Coverage
<b>REHABILITATION AND HABILITATION SERVICES:</b> Physical, Speech, and Occupational Therapy and Applied Behavior Analysis <i>(Limited to 60 total inpatient days and 30 total outpatient visits per Calendar Year for medical diagnoses)</i>	90% Coverage
<b>HOME HEALTH CARE SERVICES:</b>	90% Coverage
<b>CHIROPRACTIC SERVICES:</b> <i>(No PCP Referral Required. Covered up to 25 visits per Calendar Year)</i>	\$40 Copayment per visit
<b>TEMPOROMANDIBULAR JOINT DISORDER:</b>	\$40 Copayment per visit
<b>SLEEP DISORDERS:</b>	\$40 Copayment per visit
• Sleep Study	\$200 Copayment per sleep study
<b>TRANSPLANT SERVICES:</b>	\$200 Hospital Copay/day (Days 1-5)
<b>MENTAL HEALTH &amp; SUBSTANCE USE DISORDER SERVICES:</b>	
• Inpatient Services	\$200 Copayment per day (Days 1-5)
• Outpatient Services	\$40 Copayment per visit

PHARMACEUTICAL BENEFITS	COVERAGE
<b>COVERED PRESCRIPTION DRUGS<sup>1</sup>:</b>	
• <b>Tier 1 (Preferred Generic Drugs)</b>	
○ From a Participating Pharmacy	\$10 Copayment per 30-day supply
○ Mail-order	\$24 Copayment per 90-day supply <sup>2</sup>
○ Participating Pharmacy	\$30 Copayment per 90-day supply <sup>2</sup>
• <b>Tier 2 (Non-Preferred Generic Drugs)</b>	
○ From a Participating Pharmacy	\$25 Copayment per 30-day supply
○ Mail-order	\$54 Copayment per 90-day supply <sup>2</sup>
○ Participating Pharmacy	\$75 Copayment per 90-day supply <sup>2</sup>
• <b>Tier 3 (Preferred Brand and Non-Preferred Generic Drugs)</b>	
○ From a Participating Pharmacy	\$45 Copayment per 30-day supply
○ Mail-order	\$97 Copayment per 90-day supply <sup>2</sup>
○ Participating Pharmacy	\$135 Copayment per 90-day supply <sup>2</sup>
• <b>Tier 4 (Non-Preferred Brand and Non-Preferred Generic Drugs)</b>	
○ From a Participating Pharmacy	\$70 Copayment per 30-day supply
○ Mail-order	\$175 Copayment per 90-day supply <sup>2</sup>
○ Participating Pharmacy	\$210 Copayment per 90-day supply <sup>2</sup>
• <b>Tier 5 (Preferred Biological Drugs, Biotechnical Drugs, and Specialty Pharmaceuticals<sup>3</sup> and Non-Preferred Drugs)</b>	90% Coverage
• <b>Tier 6 (Biological Drugs, Biotechnical Drugs, and Specialty Pharmaceuticals<sup>3</sup> and Non-Preferred Drugs)</b>	85% Coverage
• <b>Oral Contraceptives</b>	\$0 Copayment for generic and select brand drugs; Applicable Copayment for other brand drugs
• <b>Diabetic Testing Supplies</b> [OneTouch and Freestyle (excluding Libre) glucose meters, OneTouch and Freestyle glucose test strips, and any brand of lancets/lancet devices]	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>A 90-day supply is as written by the provider, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. <sup>3</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/plans/5PLA>.

**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](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.