# VIVA SILVER 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 |
|---|---|
| **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. See separate pharmacy deductible on next page. Amounts from manufacturer coupons or similar assistance programs used to satisfy Member Copayments or Coinsurance do not count toward the Deductible. | $6,800 per individual; $13,600 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. 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. | $9,200 per individual; $18,400 per family |
| **PREVENTIVE CARE:**<br>• Well Baby Care (Children under age 3)<br>• Routine Physicals (One per Calendar Year for ages 3+)<br>• Covered Immunizations<br>• Preventive Prenatal Care<br>• OB/GYN Preventive Visit (One per Calendar Year)<br>• Nutritionist Preventive Visits (Up to 3 per Calendar Year with a Registered Dietitian or Nutritionist)<br>• Other preventive items and services. See Certificate of Coverage for more information | 100% Coverage |
| **OTHER PRIMARY CARE SERVICES:**<br>• Medical Physician Services, Hearing Exams, Illness and Injury | $40 Copayment per visit |
| **SPECIALTY CARE:** *(No PCP Referral Required)*<br>• Medical Physician Services, OB/GYN Services, Illness and Injury | $60 Copayment per visit |
| **URGENT CARE CENTER SERVICES:**<br>• Medical Physician Services, Illness and Injury | $60 Copayment per visit |
| **TELADOC TELEHEALTH SERVICES:**<br>• Primary/Urgent Care Consultations<br>• Behavioral Health Consultations | $55 per consultation<br>$60 per consultation |
| **PEDIATRIC VISION CARE:** *(Covered for children ages 0 until age 19; No PCP Referral Required)*<br>• One routine vision exam per plan year for children ages 0 until age 19<br>• Contacts or one pair of eyeglasses per plan year for children ages 0 until age 19<br>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 www.vsp.com/advantage or call 1-855-868-4561. See Attachment C for more information. | 100% Coverage |
| **PEDIATRIC DENTAL CARE:** *(Covered for children ages 0 until age 19)*<br>For more information, go to www.deltadentalins.com/vivaehb or call 1-800-471-8148. | Pediatric dental benefits provided by **Delta Dental PPO**. |
| **ALLERGY SERVICES:** *(No PCP Referral Required)*<br>• Physician Services<br>• Testing and Treatment | $60 Copayment per visit<br>65% Coverage after deductible |
| **CHRONIC CARE MAINTENANCE:** *(Including but not limited to dialysis, radiation therapy, wound care, wound therapy)* | 65% Coverage after deductible |
| **LABORATORY SERVICES:**<br>• Laboratory Procedures<br>• Covered Genetic Testing | 100% Coverage<br>65% Coverage after deductible |
| **DIAGNOSTIC SERVICES:**<br>• X-Rays<br>• Other Diagnostic Services *(Including but not limited to CT Scan, MRI, PET/SPECT, ERCP)* | 100% Coverage after deductible<br>65% Coverage after deductible |
| **OUTPATIENT SERVICES:**<br>• Surgery and Other Outpatient Services<br>• Outpatient Hospital Observation (no procedure performed) | 65% Coverage after deductible<br>$500 Copayment per day |
| **HOSPITAL INPATIENT SERVICES:**<br>• Physician and Facility Services | $500 Copayment per day (Days 1-5) |
| **MATERNITY SERVICES:**<br>• Physician Services *(Prenatal, delivery, and postnatal care)*<br>• Maternity Hospitalization | $60 Copayment per delivery<br>$500 Copayment per day (Days 1-5) |

**Newborn care and other services covered only 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.**

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|---|---|
| **EMERGENCY ROOM SERVICES:** | $570 Copayment |
| **EMERGENCY AMBULANCE SERVICES:** *(Must be Medically Necessary)* | 65% Coverage after deductible |
| **DURABLE MEDICAL EQUIPMENT AND PROSTHETIC DEVICES:** | 65% Coverage after deductible |
| **SKILLED NURSING FACILITY SERVICES:** *(100 days per Lifetime)* | 65% Coverage after deductible |
| **MEDICAL NUTRITION SERVICES:** *(Limited to 6 visits per Calendar Year with a Registered Dietitian or Nutritionist)* | $60 Copayment per visit |
| **DIABETES SELF-MANAGEMENT EDUCATION:** | $60 Copayment per visit |
| **DIABETIC SUPPLIES:** Insulin covered under prescription drug rider. For Diabetic Supplies call VIVA HEALTH. | 65% Coverage after deductible |
| **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)* | 65% Coverage after deductible |
| **HOME HEALTH CARE SERVICES:** | 65% Coverage after deductible |
| **CHIROPRACTIC SERVICES:** *(No PCP Referral Required. Covered up to 25 visits per Calendar Year)* | $60 Copayment per visit |
| **TEMPOROMANDIBULAR JOINT DISORDER:** | $60 Copayment per visit |
| **SLEEP DISORDERS:** | $60 Copayment per visit |
| • Sleep Study | 65% Coverage after deductible per sleep study |
| **TRANSPLANT SERVICES:** | $500 Hospital Copayment per day (Days 1-5) |
| **MENTAL HEALTH & SUBSTANCE USE DISORDER SERVICES:** | |
| • Inpatient Services | $500 Copayment per day (Days 1-5) |
| • Outpatient Services | $60 Copayment per visit |

| PHARMACEUTICAL BENEFITS | COVERAGE |
|---|---|
| **PHARMACY DEDUCTIBLE:** Applies to all drugs with coinsurance coverage when the Member pays a set percentage of the cost (Tiers 5 and 6). Deductible must be satisfied before cost-sharing applies. | $2,450 per individual |
| **COVERED PRESCRIPTION DRUGS[1]:** | |
| • **Tier 1 (Preferred Generic Drugs)** | |
| ○ From a Participating Pharmacy | $15 Copayment per 30-day supply |
| ○ Mail-order | $38 Copayment per 90-day supply[2] |
| ○ Participating Pharmacy | $45 Copayment per 90-day supply[2] |
| • **Tier 2 (Non-Preferred Generic Drugs)** | |
| ○ From a Participating Pharmacy | $30 Copayment per 30-day supply |
| ○ Mail-order | $65 Copayment per 90-day supply[2] |
| ○ Participating Pharmacy | $90 Copayment per 90-day supply[2] |
| • **Tier 3 (Preferred Brand and Non-Preferred Generic Drugs)** | |
| ○ From a Participating Pharmacy | $65 Copayment per 30-day supply |
| ○ Mail-order | $163 Copayment per 90-day supply[2] |
| ○ Participating Pharmacy | $195 Copayment per 90-day supply[2] |
| • **Tier 4 (Non-Preferred Brand and Non-Preferred Generic Drugs)** | |
| ○ From a Participating Pharmacy | $100 Copayment per 30-day supply |
| ○ Mail-order | $250 Copayment per 90-day supply[2] |
| ○ Participating Pharmacy | $300 Copayment per 90-day supply[2] |
| • **Tier 5 (Preferred Biological Drugs, Biotechnical Drugs, and Specialty Pharmaceuticals[3] and Non-Preferred Drugs)** | 70% Coverage |
| • **Tier 6 (Biological Drugs, Biotechnical Drugs, and Specialty Pharmaceuticals[3] and Non-Preferred Drugs)** | 65% Coverage |
| • **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 |

[1]Some medications may require prior authorization from VIVA HEALTH. For further information, please contact Customer Service at the phone number listed below. [2]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. [3]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/5SLV.

**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.