VIVA SILVER LITE 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 medical and pharmaceutical benefits with coinsurance coverage when the Member pays a set percentage of the cost. Does not apply to benefits with a copayment. Deductible must be satisfied before cost-sharing applies. Amounts from manufacturer coupons or similar assistance programs used to satisfy Member Copayments or Coinsurance do not count toward the Deductible.	$9,200 per individual; $18,400 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, and other cost-sharing 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: • Well Baby Care *(Children under age 3)* • Routine Physicals (*One per Calendar Year for ages 3+)* • Covered Immunizations • Preventive Prenatal Care • OB/GYN Preventive Visit (One per Calendar Year) • 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	$45 Copayment per visit
SPECIALTY CARE: *(No PCP Referral Required)* • Medical Physician Services • OB/GYN Services • Illness and Injury	$70 Copayment per visit
URGENT CARE CENTER SERVICES: • Medical Physician Services • Illness and Injury	$70 Copayment per visit
TELADOC TELEHEALTH SERVICES: • Primary/Urgent Care Consultations • Behavioral Health Consultations	$55 per consultation $70 per consultation
PEDIATRIC VISION CARE: *(Covered for children ages 0 until age 19; No PCP Referral Required)* • One routine vision exam per plan year for children ages 0 until age 19 • Contacts or one pair of eyeglasses per plan year for children ages 0 until age 19 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)* 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)* • Physician Services • Testing and Treatment	$70 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
LABORATORY SERVICES: • Laboratory Procedures • Covered Genetic Testing	100% Coverage 100% Coverage after deductible
DIAGNOSTIC SERVICES: *(Including but not limited to X-Rays, CT Scan, MRI, PET/SPECT, ERCP)*	100% Coverage after deductible
OUTPATIENT SERVICES: • Surgery and Other Outpatient Services • Outpatient Hospital Observation (no procedure performed)	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.**	$70 Copayment per delivery 100% Coverage after deductible
EMERGENCY ROOM SERVICES:	$650 Copayment per visit
EMERGENCY AMBULANCE SERVICES: *(Must be Medically Necessary)*	100% Coverage after deductible
DURABLE MEDICAL EQUIPMENT AND PROSTHETIC DEVICES:	100% Coverage after deductible

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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)*	$70 Copayment per visit
DIABETES SELF-MANAGEMENT EDUCATION:	$70 Copayment per visit
DIABETIC SUPPLIES: Insulin covered under prescription drug rider. For Diabetic Supplies call VIVA HEALTH.	100% 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)*	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)*	$70 Copayment per visit
TEMPOROMANDIBULAR JOINT DISORDER:	$70 Copayment per visit
SLEEP DISORDERS:	$70 Copayment per visit
• Sleep Study	100% Coverage after deductible per sleep study
TRANSPLANT SERVICES:	100% Coverage after deductible
MENTAL HEALTH & SUBSTANCE USE DISORDER SERVICES:	
• Inpatient Services	100% Coverage after deductible
• Outpatient Services	$70 Copayment per visit

PHARMACEUTICAL BENEFITS	COVERAGE
PHARMACY DEDUCTIBLE: See Calendar Year Deductible above. Calendar Year Deductible also 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.	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[2]
○ Participating Pharmacy	$30 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	$80 Copayment per 30-day supply
○ Mail-order	$200 Copayment per 90-day supply[2]
○ Participating Pharmacy	$240 Copayment per 90-day supply[2]
• **Tier 5 (Preferred Biological Drugs, Biotechnical Drugs, and Specialty Pharmaceuticals[3] and Non-Preferred Drugs)**	100% Coverage after deductible
• **Tier 6 (Biological Drugs, Biotechnical Drugs, and Specialty Pharmaceuticals[3] and Non-Preferred Drugs)**	100% Coverage after deductible
• **Oral Contraceptives**	$0 Copay for generic and select brand drugs; Applicable Copay 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]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 www.vivahealth.com/Group/plans/5SLT.

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.