VIVA CHOICE

Effective Dates: January 1, 2025 – December 31, 2025

Attachment A to Certificate of Coverage

The Plan's services and benefits, with their coinsurance, and some of the limitations, are listed below. Please remember that this is only a brief listing. For further information, plan guidelines, and exclusions, please see the Certificate of Coverage. This health plan is part of a consumer-driven health plan that pairs the health plan benefits with a health savings account (HSA). Funds distributed into an HSA for use with this health plan, up to the annual contribution limit, are tax-deductible and funds in an HSA grow tax-free. You can withdraw funds from your HSA to pay for qualified medical expenses, like deductibles and coinsurance, without penalty. To be eligible for an HSA you must be covered under a high deductible health plan, among other requirements set forth by the IRS.

Please keep this Attachment A for your records.

MEDICAL BENEFITS	COVERAGE
CALENDAR YEAR DEDUCTIBLE: Applies to all benefits except preventive care services covered at no charge. If your coverage tier is anything other than single coverage, you must meet the aggregate family deductible. Amounts from manufacturer coupons or similar assistance programs used to satisfy Member Coinsurance do not count toward the Deductible.	Individual plan deductible: $1,650; Family plan deductible $3,300 (aggregate amount 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 and coinsurance paid by the Member for qualified services but does not include premiums or out-of-network charges over the maximum payment allowance. See the Certificate of Coverage for details. Amounts from manufacturer coupons or similar assistance programs used to satisfy Member Coinsurance do not count toward the Out-of-Pocket Maximum.	$3,550 per individual; $7,100 aggregate amount 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** • **Illness and Injury** • **Hearing Exams** • **X-Ray and Laboratory Procedures** *(Including covered genetic testing)*	90% Coverage
SPECIALTY CARE: *(No PCP Referral Required)* • **Medical Physician Services** • **Illness and Injury** • **OB/GYN Services** • **X-Ray and Laboratory Procedures** *(Including covered genetic testing)*	90% Coverage
URGENT CARE CENTER SERVICES: • **Medical Physician Services** • **Illness and Injury**	90% Coverage
VISION CARE: *(No PCP Referral Required)* • **One routine vision exam per Calendar Year** • **Other eye care office visits**	90% Coverage
ALLERGY SERVICES: *(No PCP Referral Required)* • **Physician Services and Testing**	90% Coverage
DIAGNOSTIC SERVICES: *(Including but not limited to CT Scan, MRI, PET/SPECT, ERCP)*	90% Coverage
OUTPATIENT SERVICES: • **Surgery and Other Outpatient Services**	90% Coverage
HOSPITAL INPATIENT SERVICES: • **Physician and Facility Services**	90% Coverage
INFERTILITY SERVICES: *(Subject to a $5,000 maximum family medical lifetime benefit and a separate $5,000 maximum family prescription drug lifetime benefit. Eligibility limited to subscriber and/or subscriber's spouse.)*	
• **Initial consultation and counseling session**	90% Coverage; One per Lifetime
• **Semen analysis, HSG test, and endometrial biopsy**	90% Coverage; One per Lifetime
• **Medically Necessary office visits and tests** (ultrasound, laboratory tests)	90% Coverage
• **Prescription drugs**	90% Coverage
• **Medical services to treat infertility** [assisted reproductive technology (ART), including intrauterine insemination (IUI) and in vitro fertilization (IVF)]	90% Coverage
MATERNITY SERVICES: • **Physician Services** (Prenatal, delivery, and postnatal care) • **Maternity Hospitalization**	90% Coverage
Newborn care and other services covered <u>only</u> for enrolled child of employee or employee's spouse. Eligible baby must be enrolled in plan within 30 days of birth or adoption for baby's care to be covered. No coverage for children of employee's dependent child.	
EMERGENCY ROOM SERVICES: Members can use participating urgent care facilities in urgent but non-emergency situations	90% Coverage
EMERGENCY AMBULANCE SERVICES: *(Must be Medically Necessary)*	90% Coverage
DURABLE MEDICAL EQUIPMENT AND PROSTHETIC DEVICES:	90% Coverage
SKILLED NURSING FACILITY SERVICES: *(Limited to 60 days per Calendar Year)*	90% Coverage

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MEDICAL BENEFITS	COVERAGE
DIABETES SELF-MANAGEMENT EDUCATION:	90% Coverage
DIABETIC SUPPLIES: Insulin covered under prescription drug rider. For Diabetic Supplies call VIVA HEALTH.	90% Coverage
MEDICAL NUTRITION SERVICES: *(Limited to 6 visits per Calendar Year with a Registered Dietitian or Nutritionist)*	90% Coverage
REHABILITATION AND HABILITATION SERVICES: Physical, Speech, and Occupational Therapy and Applied Behavior Analysis	90% Coverage
HOME HEALTH CARE SERVICES: *(Limited to 60 visits per Calendar Year)*	90% Coverage
CHIROPRACTIC SERVICES: *(No PCP Referral Required)*	90% Coverage
TEMPOROMANDIBULAR JOINT DISORDER:	90% Coverage
SLEEP DISORDERS:	90% Coverage
TRANSPLANT SERVICES:	90% Coverage
MENTAL HEALTH & SUBSTANCE USE DISORDER SERVICES:	
• **Inpatient Services**	90% Coverage
• **Outpatient Services**	

PHARMACEUTICAL BENEFITS	COVERAGE
COVERED PRESCRIPTION DRUGS[1]:	
• **Generic Drugs**	
○ From a Participating Pharmacy	90% Coverage
○ Mail-order	90% Coverage per 90-day supply[2]
○ Participating Pharmacy	90% Coverage per 90-day supply[2]
• **Preferred Brand and Non-Preferred Generic Drugs**	
○ From a Participating Pharmacy	90% Coverage
○ Mail-order	90% Coverage per 90-day supply[2]
○ Participating Pharmacy	90% Coverage per 90-day supply[2]
• **Non-Preferred Brand and Non-Preferred Generic Drugs**	
○ From a Participating Pharmacy	90% Coverage
○ Mail-order	90% Coverage per 90-day supply[2]
○ Participating Pharmacy	90% Coverage per 90-day supply[2]
• **Biological Drugs, Biotechnical Drugs, and Specialty Pharmaceuticals[3]**	90% Coverage
• **Weight Loss Drugs (Contrave, Qsymia, Saxenda, and Wegovy)[4]**	70% Coverage
• **Oral Contraceptives**	$0 Copayment for generic and select brand drugs; Applicable Coinsurance for other brand drugs
• **Diabetic Testing Supplies**	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/Login/ [4]Cost Sharing for weight loss drugs (Contrave, Qsymia, Saxenda, and Wegovy) does not apply to drugs prescribed for diabetes. Cost Sharing for drugs prescribed for diabetes follows standard formulary tiering.

When generic is available, Member pays difference between generic and Brand price.
Check with your participating pharmacy to learn if it is eligible to offer a 90-day supply at retail.

SMOKING CESSATION PRODUCTS: Two, 12-week treatment courses total per Calendar Year. Prescription required. [Generic nicotine replacement products (including the patch, lozenge, gum, inhaler, or nasal spray), or Nicotrol (inhaler), or Nicotrol NS (nasal spray), or Generic Zyban, or Varenicline tartrate (Chantix)].	$0 Copayment
DEPENDENT STUDENT BENEFITS: (Emergencies and in-area care are covered under the appropriate sections set forth in the Certificate of Coverage.)	Services to treat an illness or injury for Covered Dependents will be covered while they are full-time students at an accredited educational institution out of the Service Area, subject to the Coinsurance and Deductible described herein and a $1,500 maximum benefit per Calendar Year.
SABBATICAL: (Sabbatical leave is a period of paid leave granted to faculty members by the Employer to pursue professional development, a program of investigation, creative writing, or artistry, and the like.)	Services to treat an illness or injury for Subscribers and Covered Dependents on Sabbatical Leave will be covered while they are out of the Service Area, subject to the Coinsurance and Deductible described herein and a $1,500 maximum benefit per Calendar Year.

VIVA HEALTH Customer Service: (205) 558-7474 or 1-800-294-7780 | Visit our Website at www.vivahealth.com

Eligible Dependent: To be eligible to enroll as a Covered Dependent, a person must be listed on the enrollment application completed by the Subscriber, reside in the Service Area or with the Subscriber (exceptions apply), and meet additional qualifying criteria. For exceptions and additional qualifying criteria, please refer to the Certificate of Coverage.

Pre-Existing Condition Policy: No pre-existing condition exclusions or waiting period.

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 (including sex characteristics, including interstitial intersex traits; pregnancy or related conditions; sexual orientation; gender identity; and sex stereotypes). VIVA HEALTH does not exclude people or treat them differently because 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).