VIVA BRONZE WELLNESS HSA Eligible

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.** This health plan is eligible to pair 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, such as this, among other requirements set forth by the IRS. 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 to **all benefits** except for Teladoc telehealth, dental, vision, insulin, select diabetic testing supplies at retail pharmacy and preventive care services covered at no charge. You must pay all of the cost for Covered Services until the deductible is satisfied, except as noted above. Amounts from manufacturer coupons or similar assistance programs used to satisfy Member Copayments or Coinsurance do not count toward the Deductible.	$5,700 per individual; $11,400 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 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.	$8,300 per individual; $16,600 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 • X-Rays	60% Coverage after deductible
SPECIALTY CARE: *(No PCP Referral Required)* • Medical Physician Services • OB/GYN Services • Illness and Injury	60% Coverage after deductible
URGENT CARE CENTER SERVICES: • Medical Physician Services • Illness and Injury	60% Coverage after deductible
TELADOC TELEHEALTH SERVICES: • Primary/Urgent Care Consultations • Behavioral Health Consultations	$55 Copayment per consultation See Teladoc for pricing
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	60% Coverage after deductible
CHRONIC CARE MAINTENANCE: *(Including but not limited to dialysis, radiation therapy, wound care, wound therapy)*	60% Coverage after deductible
LABORATORY SERVICES: • Laboratory Procedures and Covered Genetic Testing	60% Coverage after deductible
DIAGNOSTIC SERVICES: *(Including but not limited to X-Ray, CT Scan, MRI, PET/SPECT, ERCP)*	60% Coverage after deductible
OUTPATIENT SERVICES: • Surgery and Other Outpatient Services	60% Coverage after deductible
HOSPITAL INPATIENT SERVICES: • Physician and Facility Services	60% Coverage after deductible
EMERGENCY ROOM SERVICES:	60% Coverage after deductible

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

PHARMACEUTICAL BENEFITS	COVERAGE
COVERED PRESCRIPTION DRUGS[1]:	
• **Tier 1 (Preferred Generic Drugs)**	
○ From a Participating Pharmacy	60% Coverage after deductible per 30-day supply
○ Mail-order	60% Coverage after deductible per 90-day supply[2]
○ Participating Pharmacy	60% Coverage after deductible per 90-day supply[2]
• **Tier 2 (Non-Preferred Generic Drugs)**	
○ From a Participating Pharmacy	60% Coverage after deductible per 30-day supply
○ Mail-order	60% Coverage after deductible per 90-day supply[2]
○ Participating Pharmacy	60% Coverage after deductible per 90-day supply[2]
• **Tier 3 (Preferred Brand and Non-Preferred Generic Drugs)**	
○ From a Participating Pharmacy	60% Coverage after deductible per 30-day supply
○ Mail-order	60% Coverage after deductible per 90-day supply[2]
○ Participating Pharmacy	60% Coverage after deductible per 90-day supply[2]
• **Tier 4 (Non-Preferred Brand and Non-Preferred Generic Drugs)**	
○ From a Participating Pharmacy	60% Coverage after deductible per 30-day supply
○ Mail-order	60% Coverage after deductible per 90-day supply[2]
○ Participating Pharmacy	60% Coverage after deductible per 90-day supply[2]
• **Tier 5 (Preferred Biological Drugs, Biotechnical Drugs, and Specialty Pharmaceuticals[3] and Non-Preferred Drugs)**	60% Coverage after deductible
• **Tier 6 (Biological Drugs, Biotechnical Drugs, and Specialty Pharmaceuticals[3] and Non-Preferred Drugs)**	55% Coverage after deductible
• **Covered Insulin**	100% Coverage (Deductible does not apply)
• **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]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/5BON.

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.